SUPPORTIVE FAMILY MUSIC THERAPY

FOR FAMILIES WITH A HOSPITALIZED CHILD

Thesis

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INTRODUCTION

The purpose of this study is to develop a model of supportive family music therapy for families with chronically ill children. Supportive family music therapy is defined as therapy sessions involving the parent(s), child, and music therapist, designed to support the coping skills and reduce the anxiety level of participants. The study will evaluate current goals and treatment approaches in family-centered care, and help determine if music therapy can be an effective family intervention in the hospital setting.

Problem:

Parents with children in a pediatric hospital setting are faced with a barrage of environmental stressors that go beyond the problems normally addressed in a child's early years. They have indicated that 3 of their highest stressors are emotional reactions to their children's illnesses, alterations in their traditional parenting roles, and difficulties communicating with hospital staff (Carter, Eberly, Hennessey, Miles, and Riddle, 1989; Feldman, Horn, and Ploof, 1995; Robinson, 1987). Until these stressors are reduced, the parent's capacities for emotional support and availability to their child are diminished. While addressing parental needs through family-centered hospital care is becoming a priority, it is natural that the first concern of medical staff remains tending to the ill child. Providing feasible means of support to family members as well as children remains a

challenge. It is necessary to meet this challenge for the well-being of parents and children alike (Pearl, 1993).

The impact of parental stress from having a hospitalized child is not limited to the hospital environment or the context of the child's illness. The effects of this stress are generally carried over into family interactions both within and outside of the hospital. The necessity of adapting to new roles can leave parents floundering in search of new approaches to communication with spouses and children. It is difficult for families to view these problems in relation to anything beyond the crisis situation (Molinari, et. al., 1994). Therefore, parents, like hospital staff, are more likely to focus on curing the child, versus curing the family as a functioning unit. Bypassing the needs of the parents increases distress and coping difficulties (Barakat, 1996) as well as future behavioral problems for the child (Kinsella, et. al, 1999). A cyclic situation is formed in which ignoring the peripheral problems of the parents leads to figural problems in family relationships and communication.

A theoretical approach to supportive family music therapy will be constructed based on the need for reducing the parental stresses of the hospital environment. Some of the potential advantages of using music therapy with this population are the ability to create a supportive holding space, the normalization of the hospital environment, an opportunity for role adaptation and rehearsal, and the engagement of parents and children in a mutual affective experience. It is believed that these conditions will help parents and children adjust to their new roles, reduce some of the stresses associated with the hospital environment, and improve the overall quality of life for family members.

Rationale:

Parents are expected to be "the main constant" for their young children, (Leff & Walizer, 1992; Shelton et al., 1992), yet their caretaker roles become ambiguous in the domain of medical staff. Parents are often forced to wait patiently while their children are subjected to routine and emergency procedures. The lack of ability to participate in this aspect of their child's care causes families to experience a loss of perceived control over their situation (Bournes & Mitchell, 2002). Music therapy has the ability to address this lack of perceived control and confusion over role adaptation by bringing the family into a more "normal" environment. Family members experience what Ulman, (1978), refers to as "generational leveling". Parents are drawn into a mutual experience with the child, sharing a common mood state and being offered the opportunity to participate in their child's care.

The need for social support to maintain their well-being (Olsson, 1997) may also be denied to parents who are unsure of how to interact and communicate with hospital staff. Information can be an important source of power and control in a strange situation, and this power is generally consolidated by medical practitioners, rather than parents (Trostle, 1988). The uncertainty arising from lack of applicable knowledge can further limit the potential involvement of concerned parents.

Supportive family music therapy offers several potential benefits to this population. Group music therapy in general has the ability to lower participants' defenses, allowing them to get in touch with and address their emotional and environmental stress (Waldon, 2001). Music therapy can help to create functional boundaries for families and staff, as well as improving the communication between these

groups (Miller, 1994). Assisting family members in identifying and working through their emotions can also reduce anxiety (Hibben, 1992). Parents and children will be able to share their experiences and emotions without the need for vocabulary that may be particularly difficult for young children. The opportunity to communicate with their child as well as the music therapist may give parents a more concrete contribution to their child's well-being than waiting on the sidelines. Allowing parents to participate in the treatment of their child can lower parental stress and help the family members adjust to their altered roles (McDonnell, 1984). Reducing the anxiety and increasing the coping behaviors of parents may have the added benefit of facilitating some of the same effects in their children (Barakat & Boyer, 1996).

It is necessary to evaluate the most effective means of offering support to family members in the hospital setting. This study will help to determine how a supportive family music therapy approach can address the relevant concerns of each client.

Historical Background:

In 1989 Miles et. al published a study evaluating the sources of stress for parents with hospitalized children using the Parental Stressor Scale: Pediatric ICU. It was concluded that role changes in the traditional family relationships caused the greatest stress for parents in the ICU environment. Parents experienced a strong sense of frustration and anxiety at their perceived helplessness in assisting their children. It was suggested that future family care programs focus on the interaction between parents and children. A second study (Kasper, 1988) identified some of the primary needs of parents on a PICU as being with their child, receiving adequate information from staff about

progress and procedures, and participating as much as possible in their child's care. The majority of studies involving the reduction of parental stress have focused on decreasing general anxiety, rather than addressing these specific stressors and needs.

Curley's study, published in 1988, was the first clinical testing of a nursing model designed to reduce parental stress in the PICU. Results indicate that parental stress was effectively decreased by such nursing methods as showing concern for the parents' emotional states, ascertaining parental goals, expectations, and perceptions, and including parents in the decision-making process. Time and staffing constraints in nursing departments do not always make this interaction with parents feasible. Music therapy has the added benefit of addressing the needs of the entire family (patient and family) at once, and building on an affective form of communication, (musical tone and timbre).

Curley's study, along with Jay's 1977 publication, suggests that staff interventions and support are essential to facilitating healthy parent-child relations in the hospital environment. Increasing parental perception of control may be one way of facilitating coping behaviors and healthier interactions with both staff and children. Helping family members to rehearse their new roles in a non-threatening environment may also alleviate some of the stress caused by dramatic changes in a family's routine. Miles stresses the need for the development and research of additional protocols to provide these family services.

Bailey (1984) and McDonnell (1984) have published two of the few studies involving family music therapy in a pediatric setting. Both studies indicate that the inclusion of parents in treatment is important for the well-being of parents and children alike. Bailey's work focuses on the use of songs to help cancer patients and family

members get in touch with and express their emotions. The article looks at goals and song themes that may be appropriate, and discusses two specific cases in which this approach was applied. McDonnell's research also focuses on two cases, and describes the methods used with each family. The development of a theoretical model encompassing various possibilities for music therapy experiences does not seem to have been a primary focus with this population.

Method:

Music therapy sessions will be designed to address the environmental stressors listed above, and to help family members build adaptive methods of communication. The natures of the goals in this model lend themselves to a supportive psychotherapy model. In an insight-oriented approach the impact of past experiences and the challenging of defenses would be a therapeutic focus. While supportive psychotherapy is similar to insight-oriented therapy in concentrating on the experiences happening in the moment of therapy, it differs by reinforcing existing defense and coping mechanisms.

During the music therapy sessions, supportive psychotherapy techniques will be used to minimize anxiety and maximize positive interactions. The therapist will seek to reinforce parental ego strengths (such as mastery, reality testing, and adaptive defenses) rather than challenging their perceptions. The music will act to create a holding environment for the emotional experiences of each family member. Verbal interactions will be direct and conversational, rather than insight oriented. The supportive therapy and verbal interactions will be used in conjunction with musical improvisation to make the clients aware and expressive of the here-and-now, versus exploring reactions based on

past events. The therapist may also have the opportunity to model behavior for the parents, in terms of using the music as a support system and interacting or communicating with other family members. Music therapy goals for families may include immediate needs (crisis or trauma reactions) as well as the long-term goals of increased parental adaptation and improved parent-child relations.

This approach is designed to elicit change in three aspects of the family's hospital experience. First, patients and family members will develop a stronger awareness of their personal experiences and emotional reactions. Second, family members will explore new ways of communicating and sharing each other's experiences. Third, parents and children will test out the potential strengths of their new roles and relationships. It is expected that sharing the experience of the supportive music environment will allow families to rehearse new behaviors and become more comfortable in their personal styles of communication.

Limitations:

This study is delimited by the primary goals established by the therapist. While role adaptation, parental perception of control, and relational/communication styles between family members are important areas to be addressed with this population, additional effects of music therapy might be discovered in the application of other techniques or styles of therapy. The decision to make this a supportive therapy model also reduces some of the possible outcomes, such as the working through of defenses that might be uncovered in a more insight-oriented approach. While the model being developed here is based on a literature review of relevant studies conducted with this

population, this is not to say that other styles would not be effective in working towards additional goals with family groups.

One of the limitations imposed on this study will be the lack of other therapeutic models with which to compare music therapy in the treatment of this population. Time constraints of the primary therapist will also limit the gathering of observational data.

Research Objectives:

This study will aim to develop an effective model of music therapy for treating the families of hospitalized children. Treatment approaches and goals of this population will be examined with a focus on how music therapy can fulfill a current need in family-centered care. It is hypothesized that supportive family music therapy will reduce parental stress caused by the hospital environment and improve the communications and relationships of family members.

LITERATURE REVIEW

Family Responses to Hospitalization:

In 1992, a study done by Hamlett, Katz, and Pellegrini examined the impact of childhood chronic illness on family members, and looked at the resources available for family coping. An earlier article by Masters, Cerreto, and Mendlowitz, (1983), pointed out that the pre-morbid state of the family, in terms of relationships and psychological wellness, was a large factor in predicting the reactions to such a crisis situation. Hamlett et. al., (1992), sought to investigate the use of the family's strengths in combination with social resources to combat stress effects. The results of interviewing 60 mothers indicate that childhood illness is a chronic stressor both for the child and family members. This stress is viewed as a dynamic process that can be affected positively or negatively by family interactions.

Snowdon and Gottlieb, (1989), looked at six of the possible roles mothers might take on while in the hospital ward. These roles, the vigilant parent, nurturer-comforter, medical parent, caregiver, entertainer, and protector, were seen to be affected by the setting, the condition of the child, and the presence of others in the room while the mother was visiting. The most commonly assumed roles were the vigilant parent and the nurturer-comforter, two relatively passive positions. This demonstrates the pattern of parents giving over the care and control of their child to medical professionals, resulting

in high levels of anxiety and feelings of helplessness. These roles had the tendency to be altered when other visitors were present, or mothers were provided with more support from hospital staff. It was seen as essential that family-oriented services (therapy, social support), be provided to assist the parents in their emotional management and coping strategies.

Along with Kasper and Nyamathi's study, (1988), Carter et. al., (1989), assess the most stressful aspects of the hospital environment for parents. It was theorized that various types of stress (personal, situational, and environmental) interact to cause the overall stress response of the parents. Determining the specific causes of environmental stress was the first step toward providing an intervention that could impact each of these areas. The Parental Stressor Scale: Pediatric Intensive Care Unit, was administered to over 400 parents of children hospitalized in PICUs. General categories such as sights and sounds, parental role alterations, and staff communication were further divided into specific experiences that occur in the pediatric ward. Under the category of Parental Role Alteration, subjects rated their inability to protect their children and uncertainty about how to provide assistance as the most stressful items.

The study reinforces the importance of addressing the needs of the parent in this environment and lists some of the stressors that are likely to require attention. Results indicate that parent-child role alterations should be a primary focus of family interventions. Scores from the PSS: PICU also pinpoint the areas, (pain management, emotional expression, acting out behaviors) in which parents would likely to be of aid to their children. This research was designed as part of a series of studies intended to develop a model of family-centered intervention in the PICU. Kasper and Nyamathi's

study was conducted in a similar manner, substituting an open-ended questionnaire that divided parental responses into the categories of physical, psychological, and sociological needs. Suggestions for future research from these articles include evaluating the coping styles and various resources utilized by parents during this time, and examining the effect of interventions on the parent's behavior toward his or her child.

Feldman, Horn, and Ploof, (1995), begin looking at common coping strategies, and describe hospital stressors from the perspectives of both parents and medical staff. Parents and hospital staff were interviewed using a semi-structured, open-ended survey format. Results show that medical staff are aware of the most frequent causes of parental stress, and that both groups indicate parent's emotions and communication problems as the highest stressors. Staff did not demonstrate as high an awareness of the methods used by parents to deal with these stressors. Receiving accurate information and interacting with hospital staff were seen by parents as the most effective coping strategies.

A study done by Bournes and Mitchell, (2002), "Waiting: The Experience of Persons in a Critical Care Waiting Room", concurs that open and honest dialogue with a professional was the most helpful method of reducing anxiety and feelings of helplessness. Many professionals mentioned difficulties maintaining these helpful interactions due to the intensified emotional states and reactionary behaviors of parents. Over half of the families interviewed also discussed normalizing the environment as a method of reducing stress. Medical staff and family members were not clear about how to alter normal routines to best meet the needs of the child, parents, and professionals involved. It is suggested that healthcare professionals provide support by discussing problems with families, including parents in appropriate decision-making, and reviewing

possible coping strategies with new parents. These strategies are primarily didactic in nature. In contrast, the potential advantage of a music therapy intervention is helping the parents to actualize their coping skills. The music therapist can provide an experience that allows family members to test their understanding and interactions in the immediate situation.

Jay's study, (1977), discusses the impact of being patient with parents to facilitate healthy parent-child interactions. As was mentioned in the previous study, family members are likely to be experiencing strong emotional reactions to a child's illness, and may require information and policies to be explained multiple times. Every parent's immediate reaction to his or her situation is different. Parents who are uncomfortable in their altered roles should be encouraged but not forced to become closer to their child. It is important for the parent not only to make his or her own decisions about the level of interaction with the child, but also to develop a trusting relationship with the staff.

Jay also discusses, however, the necessity of parent-child relations in maintaining normal growth and development. A child whose parents have completely withdrawn may later face emotional and developmental delays. Using professionals as intermediaries may facilitate more appropriate interactions between family members. Staff should not take for granted that a parent will know how to behave correctly in the daily care-taking routine of his or her child. Answering questions thoroughly and modeling behavior are two methods of assisting parents' gradual accommodation to the hospital environment. Sunde, Mabe, and Josephson, (1993), also point out that staff can ask parents about the physical and behavioral changes in their children. This can foster a bi-directional flow of information regarding the well-being of the child, motivate the parent to fulfill a

necessary role, and create a cooperative alliance between all concerned parties. The results of Jay's study in combination with Feldman's research suggest that creating a normalized environment or experience can be essential in holding on to a healthy family dynamic. Encouragement and support can lead to parent-child relations that will promote development and well-being of parent and child alike.

Bradford and John's article, (1991), describes the most important steps in establishing a family-care model in the pediatric ward. These steps, from the initial planning of an intervention to closure with family and staff, can help bring families and staff together in unfamiliar territory. The process begins with holding an initial meeting with hospital staff and considering the possible needs of the family as well as the optimal number and type of professionals to be involved. This is followed by setting a time to confer with the family, update treatment-team meetings, and eventual closure and discharge of the family from the hospital. A family therapist is generally included in these meetings. This therapist has the opportunity to spend time individually with families and facilitate increased communication between parents and multiple levels of hospital staff, allowing parents to be involved in the care of their children while providing medical personnel with continued updates and necessary information.

Bradford and John emphasize the benefits this form of intervention can have not only for family and staff, but also for the child himself. When the parent has an active role in the child's care, he or she can assist the child with anxiety and coping skills. Boyer and Barakat's study, (1996), "Mothers of Children with Leukemia: Self-Reported and Observed Distress and Coping During Painful Pediatric Procedures", further points out that decreasing parental distress may lead to a reduction in the child's distress. Nurses

and physicians also come to a better understanding of the family and child's emotional concerns. Lynch et. al. agree that parent-staff interactions are important to increase the likelihood of identifying psychosocial problems with hospitalized children. These articles are a reminder that when considering a family therapy intervention, parents and staff both have needs to be met.

Curley worked to take these needs into consideration in her 1988 application of a nursing participation model of care used with parents in the pediatric intensive care unit. This model uses four steps of action to provide optimal care for the parents of sick children. The system begins with open-ended questions designed to give the family a feeling of worth and independence. Parents are then asked to discuss their goals, expectations, and concerns regarding their children. Third, nurses work to assess the parental perspective on the illness of the child. Family members are approached differently based upon their attitudes and beliefs, and staff try to clarify medical information and procedures. Parents are then asked for their suggestions and contributions to the child's care. Results of the study indicate that this model of care was helpful in reducing the stress of parents (based on responses to the Parental Stressor Scale: Pediatric Intensive Care Unit), and that time alone was not a significant factor alleviating parental stress. This demonstrates that sharing information with parents and discussing their care-taking roles can be an effective intervention.

Two of the greatest differences between Curley's model and the proposed music therapy intervention are simultaneous treatment of parents and child, and normalization of the hospital environment. Many healthcare professionals are concerned about the draw on available resources when addressing parental needs. An intervention that meets

parental needs without depriving the child of attention and care is more likely to be accepted in the medical field. In addition, music therapy brings the component of aesthetic appreciation to treatment. Families are engaged in a musical experience that can temporarily remove them from the stress of the hospital environment.

The Role of Family Dynamics:

One concern touched on in the previous section is how family dynamics, (the changing relationships and interactions of family members), can affect the behaviors and coping skills of parents and children. Having established that parents are strongly impacted by the hospitalization of a child, it becomes important to determine more specifically how this impact changes and is changed by family dynamics. The daily interactions of parents and children have a significant impact both on the experience of the hospital environment and re-assimilation to the home and outside world.

As discussed in the Barakat and Boyer study, parental behaviors have been shown to affect the ability of the child to utilize his/her coping skills and deal with anxiety. Outside of the hospital setting, positive interactions between family members, (such as instances of cooperation, demonstration of warmth, and the implementation of peaceful problem-solving), have also been precursors to increased adaptability and coping by children (Lindahl and Malik, 1997). It can be noted here that the primary purpose of supportive therapy is not to create dramatic change, but rather to maintain existing strengths and positive behaviors. McHale and Cowan, (1996), mention the appreciative response of families when they feel that their healthy aspects are being emphasized and supported.

Another essential component of all family dynamics is the establishment and fulfillment of certain roles. Belsky, Putnam, and Crnic, (1996), talk about how in the average 2-parent family, the mother is protective of the children while the father has a tendency for risk-taking behavior. In the case of the hospitalized child, however, both parents are more likely to be concerned about every detail that involves the potential welfare of their child. Despite the possibly short period of time spent in the hospital, these behaviors may carry over to interactions at home. There is a risk of the child losing the opportunity to identify with the different role models generally presented. Growth and development are necessarily limited when the child is only exposed to very specific roles and behavioral personalities.

Kinsella et. al., (1999), narrowed the focus of this idea by looking at how family dynamics affect the behavior of children who returned home after traumatic brain injuries. The emotional reaction of the caregivers and the support of other family members were both predictive of future behavioral patterns in children. There was a high correlation between behavior problems and difficulties in normal family functioning. It was suggested that therapy designed to improve the coping skills of the parents would have a salutary effect on children as well.

In Molinari et. al.'s 1994 study, some rationale was provided for the change in parents' behavior towards their hospitalized child. There was a general tendency for families of children with severe asthma to avoid any type of conflict. Parents became more permissive in an effort to bypass a situation in which the child could become upset. They felt that challenging the child could exacerbate his/or physical condition. Thus the normal power relationships in a family were disturbed, and all members experienced

some level of discomfort due to unclear roles. Despite the implications here to poorly defined boundaries and appropriate behavior, it was difficult for the families in this study to conceptualize their relational problems outside the context of the illness. As the figural aspect of their interactions, the child's illness was generally viewed at the core of any family dynamic issues. Shifting the focus of attention to daily interplay and the effect of role fulfillment may be a very gradual process, but was suggested as a key goal in therapy. Kinsella also emphasized the importance of early intervention for parents and an examination of pre-existing family resources and support systems.

A study by Smilkstein in 1978 looked at how to measure these resources as well as the basic functioning of families. The research focused on the necessary ability of a family to adapt based on the bio-psychological changes continuously occurring to its members. Smilkstein asserted that for a family to meet these challenges of growth and change, they must have access to certain internal and external resources. Internal resources consist primarily of the observable characteristics of family interactions, or basic functioning, divided into the categories of adaptability, partnership, growth, affection, and resolve. In addition, external resources were deemed necessary to support or develop family functioning to an appropriate level. These include social, cultural, religious, economic, educational, and medical resources. When these resources are accessible and used effectively, the level of positive family interactions is likely to increase. Assessing family functioning and resources is the first step towards providing a supportive treatment intervention. Identifying family strengths and weaknesses helps determine both whether the family requires a therapeutic intervention, and also those

areas of support (social, psychological, educational) that can be most effectively addressed by the therapist.

Family Therapy in the Hospital:

The next step in establishing a successful intervention program is looking at how family therapy can be integrated into the hospital setting. Provence, (1990), discusses some of the situations and conflicts that may arise in a family-care environment. She stresses the importance of relationships and family interaction for strengthening development and coping responses, but also indicates the difficulties inherent in this type of approach. One problem she warns about is the contagious nature of parental anxiety. While it may not be communicated in words, children are often aware of parental reactions, and these can influence the child's own fear and vulnerability. Professionals should aim to provide a supportive environment that can help parents relax, and thus contribute more effectively to their child's care. When parents are given encouragement and trust, they seem to act with more self-confidence in their care-giving abilities. This in turn can facilitate a healthier relationship with the child, and allows the parent to model coping behaviors and stability. Working cooperatively, parents and staff are each able to contribute more effectively to a therapeutic alliance designed around the child's needs. This correlation provides additional rationale for learning how to address parental needs in the pediatric setting.

Lawlor and Mattingly's article, (1998), looks at some of the problems of family-centered care from the professional's perspective. It is difficult to create boundaries for family therapy until some quantitative means are developed to assess progress. Medical

staff are more likely to concentrate on the primary patient, as he or she is seen as the client, not the family. There is a natural dichotomy in the health field between expanding services to support the family, and narrowing services down to specialize on the child's physical problems. Many medical professionals feel that their training does not give them the resources to address the physical, emotional, and psychological issues of the entire family. Conflicts may also arise in a treatment-team approach, when decision-making and control are allocated to various staff members. Lawlor and Mattingly warn that in order for family-centered care to succeed, changes have to be made in power division, organization of professional and family relationships, professional identity, and the understanding of what constitutes successful treatment.

These inherent problems may be balanced out by some of the additional reasons behind implementing family-care models. Lawlor and Mattingly also discuss the importance of family members as "change agents" for the child, and look at how therapy can influence healthy parent-child relations. Cornish, Kayser, and Hansen, (1998), outline other benefits observed after holding "decision-making forums" with families in the hospital. They feel that clarifying information between parents and staff should be a focus of family-centered care. It is also important that each party understands the goals and expectations of the other. These researchers felt that social work skills are necessary to negotiate appropriate treatment goals, information exchanges, and implementation of decisions by parents and staff.

One step in creating an equality-based relationship is looking at the family and professional's views of therapy and what constitute reasonable treatment objectives. Often when families enter into a treatment setting with one identified "patient", the goal

becomes fixing this patient and his/her symptoms. Andolfi, Ellenwood, and Wendt, (1993), warn that the therapist not be seduced into this type of alliance. It is essential here that families work cooperatively to improve interactions and relationships, rather than placing blame on one member. Other goals of family members, studied by Heller, Roccoforte, and Cook, (1997), include receiving direct support, increasing feelings of personal effectiveness by helping others in the family, and increasing the perception of social support through family communication. Facilitating communication may be a primary goal of the therapist, especially when this involves helping parents and children to "translate" messages from each other that are given and received at different levels. It is also suggested that modeling through self-disclosure or risk-taking may be necessary for establishing the trust of the parents and child as equal partners in the therapeutic alliance.

Robinson, (1987), focuses on a goal common to families and staff: the need for normalizing the hospital environment for families. Parents felt that the most important thing was for their children to lead as normal a life as possible, both in and out of the hospital. This goal may be realized by providing "normal" experiences for the child in which the parent can participate. According to Harvey, (1990), therapeutic games and activities can maintain the sense of play in the child, while providing metaphorical value to parents and staff. Once parents are aware of the ability to integrate these experiences back into normal life outside the hospital, they are more likely to feel the significance of their contributions when interacting with their children.

Music and Family Therapy:

The next decision comes in choosing which model(s) of family treatment to implement. Miller, (1994), examines three methods, (systematic, strategic, and structural family therapy) to give a background for where music therapy fits in with the field of family therapy. He describes some of the benefits of this union such as the ability to communicate with music without specific words, the ability of the therapist to observe current patterns of family interaction, and the use of structure in a session. The music therapist fits in well with the Bowenian concept of triangulation. When conflicts arise between two family members, the therapist, together with the music, serves as a third party available to relieve some of the tension. Creating music together also allows each family member to experience his or her individuality without becoming isolated. In accordance with strategic family therapy, music therapy also provides a concrete example of incongruities between thought and behavior. The music therapist can help the family to explore these incongruities through metaphor and experimentation. Third, the therapist has the opportunity to model flexible boundaries and levels of structure through the music, as in structural family therapy.

Miller, (1994), also notes the inherent pleasure in a music therapy session, as patients find their senses stimulated and curiosity peaked by the accessibility of the music. Family members are more likely to find themselves focused on the here-and-now experience as they respond to the physical, (rhythmic), mental, and emotional (metaphoric) content of the music. He points out that the visual, auditory, and kinesthetic associations evoked by the music make these experiences more accessible and memorable to the participants. Several concepts such as assessment, intervention, and

structure are illustrated, as well as how a music therapist may walk through these steps while modeling appropriate behavior for parent and child alike. The music therapist is given the opportunity to observe individual behaviors and family dynamics simultaneously as members respond to the set tasks. Being involved in the music may encourage families to listen and respond to each other, re-establishing lines of communication. The article gives some general techniques for building a successful music therapy session when working with families.

Decuir's 1991 study on trends in music and family therapy looks similarly at the benefits of using music to strengthen family communication. This article also addresses Robinson's earlier concern about providing experiences to normalize the hospital environment. Another researcher mentioned in Decuir's research, Fagan comments that "music enhances the quality of hospital life because it is non-medical, but, more importantly, it is associated with life outside of the hospital." Families may be temporarily removed from the stressors identified with the hospital environment when participating in a music therapy session. Here they are given the opportunity to regain some of the normalcy of life that exists beyond the child's illness. It is also noted that facilitating communication between family members is one of the most common goals of music therapy in this context. A supportive and non-threatening environment is offered where parents and children can share their emotions in a non-verbal manner.

Hibben, (1992), expands on this idea by discussing the use of music therapy in families with young children. The more primary, non-verbal experience of playing music together helps to bypass some of the family members' resistances. This form of communication also allows adult and child to share subjective mood states. Beyond the

recognition of working cooperatively to create the music, each participant also experiences emotional responses and reactions to the audible product. These experiences are shared on a level that may not be verbalized, especially by a young child, but which circumvents the normal defenses and uncertainties present during a traumatic situation. Family members may re-examine their typical interactions based on this unique experience and method of relating to one another. The symbolic content of music can also be much like that of a child's normal play. This once again relates to normalizing the child's environment, and also allowing the patient to express himself in a structured but undemanding way. These articles illustrate several of the benefits that can be obtained by working with families using music therapy.

Music Therapy in the Hospital:

A review of some of the overall benefits of music therapy demonstrates that it has the theoretical potential to meet several goals for the target population. The question then becomes the actual implementation of music therapy in the hospital environment. Robb's 2000 article addresses the efficacy of music therapy in a medical setting. She writes about some of the benefits to be had by including music therapy in a hospitalized child's treatment program. This information is relevant to the proposed study as parents appropriate for family music therapy can be chosen from among those with children receiving individual music therapy. The research was done to examine the validity of three hypotheses, two of which stated that "music interventions create supportive environments", and "relationships exist between supportive environments and engaging behavior". This is an essential component of both individual and family oriented music

therapy, as some of the goals in this setting are to help the child increase her level of activity, and to facilitate the involvement of the parents in active care of their child.

One of the strong points of music therapy for this population is the providence of structure. Children involved in such a therapeutic activity are given more clear expectations and consequences, as opposed to the majority of hospital procedures, which do not fit in with the child's normal cause and effect understanding. Music therapy encourages the child to make choices and become active in their environment, rather than allowing everything to happen to them without understanding the causes. Drawing on previous studies, the article mentions that, "music interventions...restore a sense of control in patients". This provides some rationale for using music therapy to restore a sense of control to parents as well.

The additional benefits described as being received by children, (autonomy support and involvement), are key concepts in interventions designed to help parents adapt to the hospital environment. Involvement in a family music therapy session may give the parent an opportunity to provide the type of support the therapist is trying to give: interest, engagement, and acceptance of the child as he or she is. Conclusions from the study also indicated that music therapy experiences were more supportive to children than other activities in the hospital environment.

Jacobowitz, (1992), addresses how to overcome some of the difficulties presented by short-term therapy in the hospital. As the number of sessions with each child or family group is unpredictable, her suggestions are helpful for developing an effective treatment procedure. One of the necessary elements for successful treatment is spontaneity. This is particularly applicable to the therapist's ability to be flexible in any given music

experience. The therapist should have a plan that can be altered to fit the mood, ability, or level of engagement of the child. Assessment is also an important tool, focusing on physical abilities, relationships with others and interactions, mood state, and perception of ongoing events. Short-term goals developed along with the immediate assessment may be expanded if the child will be receiving therapy for a longer period of time.

Brodsky, (1989), describes several important goals when working with children in isolation rooms. He talks about hope and pleasure, reminiscence, relationships, validating needs and desires, expressing feelings, dealing with anxiety over death, taking the focus of attention off the self, and coming to peace with the self. Many of these goals can be addressed in the initial session with a child, while others will take longer to approach. No matter the length of the therapy, however, Jacobowitz stresses that music is invaluable in allowing family members and staff to see the healthy parts of the child not otherwise apparent. This facet alone holds significant benefits in that children will be treated with more respect and compassion. She also states that short-term therapy can at least provide a direction for the child, guiding him and his parents towards his strengths, even after he has left the hospital.

A few studies have begun to look at how music therapy might be expanded in the hospital to assist families as well as the patients themselves. Dun, (1995), addresses once again the ability of music to normalize a child's experience. The sense of safety that a child receives in a supportive therapy environment tends to give the parents a stronger feeling of trust and security as well. To take this a step further, it is necessary to engage parents more directly with their children. It has already been shown that many parents feel helpless or unsure of their roles in the hospital. Here is the ideal opportunity for the

parents not only to feel they are engaging in a constructive activity that benefits their children, but also to establish more direct lines of communication with the ill child.

Bailey, (1984), focuses on some of the goals and themes common in treatment of cancer patients. She also looks at the needs of families and how these goals can be incorporated in a family session. Suggestions of songs that may be appropriate for addressing treatment issues are provided, and two case studies illustrate possible techniques for this population. Bailey points out that the music itself is as much a therapeutic tool as the therapist. Familiar songs can provide emotional support in an unfamiliar situation, while improvisation or song writing can help families initiate change in their personal relationships or attitudes. The article urges the utilization of the power of song to help family members relate to one another.

McDonnell's research, (1984), is similar to Bailey's, but describes additional techniques that may be used in the hospital setting. Two case studies help illustrate the potential of including family members in a music therapy session. McDonnell begins by including parents while trying to work through the emotions associated with the child's illness. The therapist is able to observe parent-child interactions while helping the parent to relax and aiding the child's coping skills. Parents are given the ability to participate and take an active role in their child's care, while at the same time expressing some of their own stress and anxiety related to the circumstances. Once the beginnings of a trusting relationship have been established, the therapist can also model appropriate behavior for all family members, helping parents to participate in their child's care and redirecting children's behaviors into more adaptive patterns. While these studies are helpful in establishing the importance of family music therapy sessions, little has been

done yet to develop a model designed to address the specific needs of the parents in this environment.

Supportive Psychotherapy:

The logic behind using a supportive versus insight-oriented model is addressed in several articles. Muran, Rosenthal, and Winston, (1999), discuss the rationale for choosing to use a supportive model with specific patients. Supportive psychotherapy can be used with higher functioning individuals who are experiencing high levels of stress and anxiety due to excessive circumstances. Therapy may focus on interpersonal relationships, dysfunctional thinking, modulating affect, and frustration tolerance. Each of these goals is valid in the context of family therapy in the hospital environment. The primary means of supportive psychotherapy are improving interpersonal interactions through awareness of affect, reduction of anxiety, and strengthening of coping skills. The relationship with the therapist is seen as an important factor in facilitating change. Rather than working to resolve unconscious conflicts, the patient uses this relationship to build self-esteem and begin trusting in their own adaptive abilities.

As with music therapy, one of the underlying aims of supportive therapy is to reduce the patient's anxiety to clear the way for growth and change. This comes about partly through the building of a "normal" relationship, in which verbal communication is more like a conversation than an interrogation. Therapist and client work together to determine well-defined tasks and goals. The therapist strives to keep the client at ease by supporting his actions and minimizing conflict. This suggests that a supportive music therapy approach could be effective in creating trusting relationships and restoring

confidence to parents in their ability to adapt to the hospital environment. The treatment alliance is also established with parents as equal partners, gradually moving the responsibility for structure into their hands. Litecky, (1998), expands on this idea in her thesis, describing how a parent can reflect upon and alter the expressions of the child. She stresses that there must be a balance between how much control the parent exerts, and how responsive she is the needs and actions of her child in order to avoid expressive or attachment disorders. By modeling supportive techniques, the therapist helps the parent to actively participate by encouraging the child and understanding his or her situation from a new perspective.

Dewald, (1994), gives a brief overview of supportive psychotherapy in terms of treatment goals, indications, and general therapeutic process. He concurs that improving the patient's adaptive abilities to his or her situation should be addressed using whatever strengths and coping skills are available. It is important to recognize that while the therapist shares responsibility for achieving goals with the patient, her primary purpose is to support the goals the patient has chosen to address. Supportive psychotherapy, like music therapy, is designed to be flexible and modified based on the patient's capabilities. Session length, level of structure, and setting are variable in accordance with reducing the anxiety of the patient and giving him a sense of control.

After establishing that most patients seeking supportive therapy are those with weaker ego strengths, unable to currently handle insight-oriented therapy, or patients who are experiencing a crisis or trauma in their lives, Dewald goes on to describe some common treatment issues. One of the primary tenets of supportive psychotherapy is to minimize the stress experienced by the client. Transference is utilized to help the patient

achieve his or her goals. This may occur through strong identification and modeling of the therapist, or the therapist may react in accordance with the transference to encourage the patient's success. Dewald suggests that one general guideline for practicing supportive psychotherapy is keeping intervention efforts ego syntonic to the patient's existing character structure. Rather than challenging the patient, the therapist seeks to encourage the use of strengths that are already present. In a family music therapy session, this might be seen in the focus of the therapist on the parents' desire to help their children. The importance of the parent-child relationship for growth and well-being can be addressed through cooperative music-making and verbal reflection.

Werman, (1981), stresses that the therapist is to act as a nurturing and supportive parent, providing grounding for the patient until his own ego strengths are restored to the point of coping with the current situation. This suggests a strong use of modeling by the therapist on how to fit an appropriate parent role. One thing the therapist must be aware of is the strong attachment likely to form with the patient, and the need to be cautious of unhealthy dependency. While it is natural for the patient to come to depend on the therapist in this relationship, it is also important for the therapist to encourage the building of the patient's own ego strengths and decision-making capabilities. This goes hand in hand with increasing the parental perception of control in the hospital environment.

METHODOLOGY

Procedures:

This model of supportive family music therapy was developed through a combination of reviewing the existing literature on medical music therapy and family therapy, and adaptations based on clinical experiences with families in the hospital environment. The approach began as a facilitation of shared music therapy experiences between music therapist, parents, and chronically ill children. The experiences were designed both to continue the work done with children on an individual basis, and moderate the role changes, (from active caregiver to passive bystander), perception of control, and anxiety level of parents. This model was particularly influenced by structural family therapy. The therapist considered the perception of roles and responsibility by each family member to be essential to adaptive interactions. Varying the level of structure provided and increasing the parent's responsibility in creating this structure was a focus of music therapy sessions.

It is important to note that in the context of the supportive family music therapy session, parents may be both nurtured and nurturing. This model views the parent as a recipient of therapy. With this in mind, it also seeks to provide the parent with methods of enhancing the child's therapeutic experience within and beyond music therapy sessions. The normal parenting role usually includes assessing and meeting the basic needs of the

child. In the hospital, these responsibilities are relinquished to medical staff. Parents can no longer meet the child's physical demands, and are unsure of how to address their emotional and psychosocial needs. The changing role of the caregiver in this environment will be examined in more detail below. Children were expected to benefit in many of the same ways that they might from an individual music therapy session, including building positive self-esteem, strengthening coping skills such as self-relaxation and cognitive problem-solving, and guiding self-awareness and expression. The actual experience of family sessions has shown the achievement of some of these goals to be limited due to family member involvement, while unexpected benefits were also received.

When approaching family members to take part in a music therapy group, it is important to consider the impact on the child and the parents or siblings as individuals, as well as the changes in family dynamics for which therapy can be a catalyst. While there are few unbendable guidelines for participation, (parent's involvement should in no way harm the child or the child's existing relationship with the therapist, parental ego strength must be sufficient to tolerate supportive therapy in the presence of the child, and parents should not use family music therapy time to address personal issues not related to the child or unable to be worked with in a limited time frame), not all families will be well suited to this particular method of therapy. Some possible limitations are discussed below.

Criteria for Inclusion in Supportive Family Music Therapy:

Three factors that should influence the therapist's subject selection for supportive family music therapy are parental attitudes towards music therapy, degree of control

exerted by the parent, and ability of the therapist to balance participation by each family member. Other aspects of treatment may also impact a parent's willingness to participate or appropriate inclusion. For instance, it is recommended by this model that the parent be approached individually about beginning family sessions. This gives the therapist the opportunity to explain some of the goals and processes of a therapy session. It also allows the parent to consider what is being offered and to make a decision independent of the child's influence. Some suggestions of how to discuss participation and goals of a family session with the parent(s) and child will be addressed in the approach section. Asking the parent in front of her child can put her in an awkward position if she is taken off guard. Some parents may unintentionally decrease the significance of their child's experiences by referring to therapy simply as "play", or suggesting that as an adult, he or she will feel silly and will not receive any real benefit by participating. This may be a way for the parent to try to reduce his own anxiety by downplaying the therapeutic aspect of music therapy.

Other parents will not understand the reasoning behind a family session, but will agree out of a sense of obligation to their child. While it is likely that parents will come to a better understanding of the possible benefits after participating in one or two sessions, it is better that they enter the therapeutic alliance knowingly and with an attitude of positive expectations, versus guilt or uncertainty. Another factor is the length of the child's hospital stay. Parents who have witnessed first hand the benefits of music therapy for their child are less likely to underestimate its potential. In an extremely short-term situation, however, where only one session may be conducted with the family, the initial

attitude and beliefs of parents may override the child's reception of the therapeutic process.

One additional consideration for the therapist is the level of distress being experienced by family members. Families in which a child has been recently diagnosed, or that have been moved from a long-term to an intensive care unit may be experiencing reactions to a crisis situation. In working with one family on the PICU, it was immediately apparent that the patient's family was under severe stress. Upon entering the room, the therapist noted that the parents displayed something akin to a startle response. After a brief explanation, the parents seemed eager to welcome the therapist into their space, and did what they could to help engage their child in the music. Caretakers at this level of anxiety may react as this family did, or may become very sensitive and suspicious of new interventions. Involving the parent as a recipient of therapy may be difficult when she is not prepared to take the entire focus of treatment off of her child. A supportive intervention can be particularly important at this point, when the parents are disoriented and may communicate this distress to the child.

Parental attitudes toward music therapy:

In many cases, the attitude of the parent or caregiver toward music therapy will impact the child significantly, even during an individual session. It is not unusual for the child to receive some sort of preparation and signaling from the parent, whether before the appearance of the music therapist, or during the introduction. It was amazing to see the differences displayed by two young boys based on the signals they were given leading into a therapy session. The first, a five-year-old boy in the hospital for a month while his leg was in traction, was uncertain at first as to whether he wished to participate in music

therapy. His aunt, in an apparent effort to make the decision easier, commented, "Let the lady do her spiel, and if you don't like it, then she'll leave". The patient eventually engaged in the music, but initiated with a very demanding agenda. The underlying message he had received from his aunt was that the therapist was there to entertain him, and that if for any reason he was not pleased, therapy would be ended. Working towards a balance of control, decision-making, and respect was a gradual process with this patient, strongly impeded by the impressions of a caregiver.

The second patient was also hospitalized for approximately one month due to a hip infection. This 13-year-old male had been creating difficulties for the staff from the beginning. After several episodes of inappropriate language and rudeness towards staff members, the patient was referred for music therapy as something that might aid in his emotional expression. Prior to the introduction of the music therapist, the patient spoke with a child life specialist with whom he had spent a large amount of time. He was told that he was expected to treat the therapist with respect and that music was a privilege that could be withdrawn if he could not behave appropriately. While intermittent conflicts with other staff continued, the boy engaged quickly in an alliance with the music therapist, and treated her consistently with respect and sincere interest. The preparation he had received, though not essential to the intervention of the therapist, benefited all involved parties. A mutual trust and respect were established at the beginning of the treatment, allowing the therapist to focus on further goals for the patient.

Assessment of a parent's suitability for family music therapy based on parental attitudes, parental exertion of control, and therapist ability to balance family member participation, should begin with the introduction of the therapist. Signals of the

caregiver's attitude may consist of comments made in front of the child, questions asked to the therapist outside of the child's room, or facial expressions and body language. These signals can indicate the parent's level of anxiety, willingness to seek help for herself and/or her child, and currently perceived role in the child's care. The therapist should also consider her own reactions to the parent(s). In situations where a parent's attitude is negative or dismissive of therapy, the therapist may choose to work solely on an individual basis with the patient. Directing excessive time and energy to changing a caregiver's beliefs should not be the focus of therapy in the time-limited hospital setting. This consideration is particularly important if the child seems strongly influenced by his parent's opinions. In these cases, inclusion of the parent can be detrimental to the child's therapeutic growth.

Parental control:

A second factor that can significantly alter the child's experience of music therapy is the amount of control exerted by the parent(s). When a parent is observing her child's individual music therapy session, she may decide to become informally involved. Since she has not been assigned a specific role in the music, her participation may take place through a control over the child's behaviors. While one of the goals of this model of therapy is to restore a sense of internal control to caregiver, the way in which this is manifested can be detrimental to the child's success. Control, as it is approached by this treatment model, involves an increased sense of participation in the child's care, and the perception that the actions of the parent are directly beneficial to and supportive of the child. In the view of this model, restoring this internal perception to the point where a parent feels he is essential to the child's care is a matter of keeping the parent in an

informed and active role. It is possible for the parent to achieve this state without feeling the need to control every aspect of the child's behavior. An excess of control-focused experiences are likely to modify parents' attitudes and behaviors at the expense of the child, by inhibiting his or her range of expression.

In a scenario where a parent already appears focused on providing structure and control for the child, it may be best to allow for some role experimentation. If the parent is consistently assigned the supportive, background position, while the child is placed in the figural role, the parent may feel more of an impulse to guide the direction of the child's expression. Parents are often subject to dualistic thinking when it comes to musical expression, in the sense that something is either right or wrong. While the therapist may make suggestions to the child of things he or she may try, these are rarely black and white demands. Parents who wish to prove that their child is as capable and creative as the next, or worry that there are wrong or "bad" notes, will attempt to reinforce a therapist's suggestions by telling the child, "No, you should play it this way," or "She said play that key first." This undermines the successful experience of the child and inhibits his freedom.

In one particular session, a four-year old boy was engaging in a referential improvisation experience, a musical improvisation based on a pre-selected topic or title. His mother was sitting close by and alternately encouraging or praising his involvement. The patient was asked to choose a "mood face", from choices provided by the therapist. The selection consisted of five paper faces, drawn to approximate the moods of happiness, sadness, sleepiness, surprise, and anger. The boy chose the angry face, and proceeded to improvise on the xylophone quickly and loudly, hitting the bars hard

enough to send them tumbling off the base. The mother backed away a bit and told her son to play more quietly, and that he would break the instrument. It is difficult for the therapist to intervene at this point without causing a split in the mother-child dynamics. There is a balance of power not only between the family members, but also between the caregivers and the therapist. While it is the parent's role to guide and reward or discipline the child, she may not be aware of the flexible boundaries in the therapy situation. The therapist may wish to address this when discussing family music therapy with a parent. It should be clarified that while the child is expected not to hurt himself or others, or to break the instruments, there is a wide range of flexibility in how the child may choose to play. In this case, the therapist did not contradict the parent, but assured the child that he would not break the instrument by playing loudly.

When the piece was finished, the therapist asked if the patient could draw a sixth mood face to add to the collection. He took the marker offered and drew in a very similar style to his musical playing: hard and fast with quick strokes. When asked which mood the face represented, the boy replied that it was also an angry face. At this point the mother commented, "No, you don't want an angry face, draw a happy face!" While it is understandable for a parent to be uncertain of how to deal openly with their child's expression of anger, sadness, or fear, it is important in this setting that children be allowed to communicate honestly what they are feeling. In this instance, the therapist felt that the mother may have been able to respond more appropriately by becoming involved in the music herself, rather than contradicting the child verbally. Logically, the idea of imitating a musical style or technique, (tempo, dynamic, attack), seems easier for an adult to process than verbally supporting the anger of her child. Spontaneously bringing the

parent into the music at this point may create a better understanding of the affective discharge being provided. Giving the parent a musical task of her own to accomplish allows her to become creative, rather than inhibitive. Some examples of the parent's ability to share this sort of affective experience with the child in a musical context will be discussed below.

Equality of family member participation:

A third consideration in family sessions is how to balance the level of desired participation from each family member. This is not based on the amount of musical production, but rather each member's level of presence and investment in the session. While in an individual session a strong and consistent engagement is a positive sign, balancing the contributions of each member of a group can be a more subtle process. It is necessary to design experiences in which each member feels valued. This often comes about because of, rather than in spite of, the availability of different musical and social roles. The musical encounter in music therapy allows for testing of otherwise foreign family dynamics. Under normal circumstances, the parent is expected to be nurturing and supportive, to provide structure for the child, and to generally put his or her own needs second to those of the child. Within the music, the child may assume any of these roles. Ideally the music therapy experience will be structured such that the parent is not threatened by becoming more of the active figure, rather than the supportive ground.

This is the opportunity for the child to initiate and direct without usurping the parent's prerogative. It is also a chance for the child to work with the therapist in supporting the parent, a dynamic that might normally cause discomfort or uncertainty on the part of the caregiver. This is not to say that a role reversal should be performed, at

least not to the extent that the child feels the burden of support, while the parent is left floundering without task or direction. Care should be taken to explore these roles gradually. The supportive musical environment gives patients the option of withdrawing to a place of comfort if this process causes undue distress.

Unlike an individual session or a group of similar-aged participants, the family group brings unusual complications of rank and power. To the toddler or school-age child, the parent is everything. Their directives are generally seen as law, and their actions, infallible. In a musical context, this may make it difficult for the child to challenge or contradict the parent. Over-involvement by the parent can intimidate the child and limit his sense of creativity and expression. While parents are generally enthusiastic about the opportunity for their child to engage in interventions such as art and music therapy, they may become so drawn into the experience themselves that they forget, momentarily, about the needs of the child.

The following example illustrates a case where the caregivers were too self-focused to be successfully involved in this family intervention. A young boy receiving a bone marrow transplant was involved in creating a song with his therapist about a transforming robot. Not recognizing the song, his mother and aunt began suggesting several other choices, including several familiar Disney and other children's songs. When the mother reached over her son to "help" him play his instrument, the boy appeared momentarily confused. He continued to play, but seemed to withdraw from the therapist for the remainder of the session. Further contact with the patient was established in a session where his mother was not present, and he gradually initiated another song

improvisation. When a child is already engaged in a musical interaction and the parent requests a new song or style, this can confuse and frustrate the child.

Parents that are unable to maintain an awareness of the child's presence in a session may be unsuitable for this type of work. While they may become the focus in a musical improvisation, this should not detract from the child's role, (whether it is supportive, imitative, or rebellious). In a family music therapy session, a parent becomes a recipient of music therapy versus an observer. At no time should the child take over the observing role. All family members are equal participants. The therapist may be able to redirect the attention of a caregiver who seems to have lost this focus. One method of re-engaging all participants is to have parents comment on music they feel has been important to their child at some point, based on preferences or shared family contexts. Parental disclosure can be helpful in eliciting further responses and details from the child. This reorients the direction of therapy to shared family experiences.

Rationale for Inclusion of the Caregiver:

The factors discussed above can be seen as both recommendations and cautions for involving parents in music therapy sessions with their children. The cautionary aspects have been explored in some detail. The question then becomes when and how to pursue engaging the parents in the music. The theory behind this model is that supportive music therapy will be beneficial for the parent as an individual, as well as a healthier member of the family group. While the child is also expected to benefit from the improvement in family dynamics, this may not be an immediate result of treatment. In a time-limited setting, the therapist must make an assessment of the figural problem(s), and

which of these concerns can reasonably be addressed through music therapy. In some cases this will mean excluding parents from the child's therapeutic process, to bypass the longer-term parental and family issues. In many situations, however, the parent can be seen as a valuable resource in treating the child. It is in these situations that supportive family music therapy is strongly recommended to strengthen coping, communication, and expression within and between family members.

Attachment issues and younger children:

Some of the difficulties discussed above can be overcome or even utilized depending on the circumstances. With infants and toddlers, for example, the caregiver is an almost essential resource. Parents of younger children are encouraged to participate on different levels based on the importance of attachment and physical sensations at this stage of development. Expressions of doubt or distrust of the music therapist can be defensive reactions against the intrusion of yet another outsider. The parent may feel that her role is being usurped by hospital staff, and projects an attitude onto the therapist that she is more capable of caring for the child than the parent herself. By involving this mother in the experience, anxious energy and role ambiguity can be redirected into goal-oriented behavior. This allows for a process of mastery in which the mother could integrate her knowledge and experience to cope successfully with the situation. It is usually not difficult to enlist the parent's support if she feels she is truly valued and needed. Some of the tasks that can be assigned to parents of infants are moral support (praise and encouragement for the child's involvement), modeling, (following the therapist's guidance to play an instrument or sing), and physical presence, (holding the child for comfort, moving with the child to the beat of the music, or helping the child to

use an instrument in a steady rhythmic way). In this type of situation, the parent is engaged in therapeutic growth, (supporting self-worth, purposeful behavior, stress reduction) through the process of helping to provide therapy for the child. These behaviors allow the parent to be involved and remain close to the child without needing to control the session.

A secondary benefit of involvement is having the parent observe the effects of music therapy on the child's well-being. Individual music therapy sessions are often directed towards self-actualization, and helping the child to become aware of himself in the moment. A parent can see the innate health of the child emerging through his musical and verbal interactions with the therapist. The patient is given the opportunity to make the environment work for him, rather than feeling it work against him. In many cases, seeing the child engaged in "normal" activity is uplifting for the parent. This is an opportunity for parents to remember that they are caring for a child with an illness, not the illness itself, isolated from the developmental context. It is not unusual for a parent to comment that it is rare to see his or her child smile, laugh, or engage in free play in the hospital. Being able to witness these behaviors can reduce the anxiety of the parent and help him or her to focus on the child's strengths. In some circumstances parents are more capable or appropriate to be a silent observer, versus a full participant in the session.

Involving the controlling parent:

In the second example, in which the mother told her son to "draw a happy face", the mother is still a resource, but one to be used cautiously. For a short-term intervention, it is recommended that the boy be treated individually, suggesting the mother use the therapy session as a chance to take some time for herself and have a break from her

vigilant care. In a longer term situation, the mother's obvious concern for her child's well-being might be channeled into a successful group music experience. Using the previous activity as a model, adaptations could be made to involve the mother more cooperatively. The therapist could set up a second instrument for the mother, and ask her to respond musically to her child's improvisation. This places the child in the leadership role, and prevents the direct verbal contradictions offered by the parent. The therapist is also able to model, following the child's lead as he initiates changes in the music. A second option is conducting two improvisations, the first initiated by the child, the second by the parent. In this case, the mother has the chance to select the "happy face" as the reference for her improvisation, without communicating that the "angry face" is wrong. This also allows the child to be drawn into the mother's projected mood state, and to explore feelings potentially outside his immediate awareness.

Unfortunately, over-involvement may be carried over into the musical experience. If a parent is incapable of taking on different roles outside of the music, building this ability through the therapy can be a very gradual process. In the meantime, the child is limited in his own expression, and further communication difficulties are potentially created. It is up to the therapist to assess each family member's ability to become a cooperative part of a group. If the therapist feels that the contribution of the parent will override the child's own success, it may be better to continue giving the child individual treatment. Again, this determination must be based on the presenting problems and the therapist's ability to address these concerns in the allotted time.

Brief Assessment Considerations:

Control issues:

While the primary purpose of this thesis is not to deal with assessment techniques, the following are some suggested guidelines for the inclusion/exclusion of parents in supportive family music therapy. The first step, as mentioned above, is identifying the most pressing issues that could be effectively addressed through music therapy. If the primary goal is helping the child to get in touch with his feelings and express himself, an over-involved parent can be more of a detriment than a resource. This is particularly true in the case of most adolescents. The ongoing struggle to establish independence during this developmental period is likely to be exacerbated by the inclusion of the parent in therapy. While some adolescents may be regressed and looking for stronger support, most patients in this age-range seem to express themselves more freely outside the presence of the caregiver.

Identifying resources and constraints:

The second step is identifying what resources are available to the family. In many cases, the parents act as resources for the child. It is also possible that the child becomes a resource for the parent, giving them direction and purpose in their struggle. When the ego strengths of the parent are insufficient for coping in the presence of the child, a family intervention is not the best option. If the child feels the necessity to "put on a happy face" for the parent, for fear of causing more stress in the family, than family dynamics should be assessed before deciding whether to include the parents in treatment. It is suggested by this model that such children be involved in both family and individual music therapy. This creates a balance between the support of the parent-child relationship, and the need for the child to be able to express less positive feelings. Family sessions can be an ideal

time to work through some of these feelings of guilt and obligation. The therapist can gradually guide the family into a contained expression of their personal fears, sadness, and anger.

Time is also an important resource. Underlying goals are often identified simultaneously to the presenting problem(s). In longer-term care, the therapist has the opportunity to address multiple concerns at the individual and family levels. In short-term situations, however, involving the family may serve to open doors to issues that cannot be resolved during the child's hospital stay. The aim of supportive therapy is to focus on the existing strengths of the family. Forcing family members together into a highly emotionally-charged situation can create more problems than it solves.

This also brings up the issue of willing participation. Parents should be given a description of the therapeutic process, or possibly a chance to observe music therapy with their child before making a decision. If the parent seems strongly resistant to the idea of therapy, this is not the ideal situation to convince them of its benefits. Engaging a caregiver in a family intervention without their fully willing consent is very likely to be damaging to the child's successful experience. A child will recognize the parent that participates out of a sense of obligation. Through body language, verbal communication, and the musical content, the child will sense and respond to the parent's reluctance. What may have begun as an exciting exploration of sounds, feelings, and associations, now becomes another form of treatment being forced on the patient externally. Therefore, when considering which parents to include in a supportive family music therapy approach, presenting problems and goals, the attitude(s) and involvement level of the

parents, the developmental stage of the child, ego-strengths of each family member, treatment duration, and a willingness to engage should all be carefully considered.

Approaching the Parent(s):

Once the therapist has decided that it is appropriate to include parents in music therapy treatment, an approach should be followed that is informative but not overwhelming. Given the tendency for parents to feel uninformed about multiple aspects of the child's treatment, it is important to provide at least a general sense of the goals and process of the music therapy in which they will be engaged. Many parents, however, may be uncomfortable with the idea of engaging as patients themselves, rather than focusing all the attention on the child. The therapist should stress the implied benefits to the child when parental stress is lowered and family communication is improved. A sample introduction based on a clinical encounter is presented below:

In this case, the child had been receiving individual music therapy on and off over the course of several months. The mother had observed parts of sessions, but had never been directly involved in the music. The idea of having the mother join the sessions was first presented to the child. Because of the nature of the therapy up to this point, the therapist felt it was important to involve the patient in this decision-making process. The therapist was also familiar enough with the mother to believe she would be interested in participating. In a situation where there is doubt as to the decision of the parent, it is recommended that the parent be approached first. This eliminates the possibility of damaging the child's ego if the mother or father does not wish to participate in therapy.

Therapist: Mrs. S., I was just speaking with your daughter about asking you to join us next week for a family music therapy session. I was wondering if you would be interested, and would be available on Monday?

Mrs. S: Was my daughter asking if I could come?

T: I mentioned the idea to her, and she seemed excited about sharing the experience with you.

S: I wouldn't mind trying it out. What sort of things would we be doing?

T: Well, we would be playing some of the familiar songs you've heard us use in sessions before, and also improvising music, often about a topic that seems important that day.

S: Is it just supposed to be fun?

T: A lot of the things we do can be fun and relaxing. The reason for having both of you involved in the music together is to give you an opportunity to share an affective experience that isn't so focused on hospital concerns. It can be very laid back, but since there are emotions involved in creating the music, it can also be serious. Sometimes family members will discover things about themselves or each other that they weren't aware of before.

S: Does that mean that it's not just about helping my daughter?

T: It doesn't mean that we stop focusing on your daughter's goals, but it gives you a chance to contribute ideas, lyrics, and music as well. It can be very helpful for family members to hear what others are thinking about, or listen to how their emotions are expressed through the music. It's a kind of safe ground to try out new things, or to share feelings with each other when you can't find the right words.

S: What if I don't know how to play?

T: Well, one of the nice things about music therapy is that there aren't really right and wrong notes. It's more about how you're interacting with each other through the music.

S: That sounds alright. My daughter does always seem to have a good time in music. I'd like to be a part of that with her.

T: I think you'll both really enjoy creating the music together. I'll stop by on Monday then, at our usual time.

Parental concerns:

The mother in this scenario raised several important questions that seem common when introducing supportive family music therapy to adults for the first time. The first question, "Was my daughter asking if I could come," concerns why the therapist is initiating a new intervention. This mother in particular was wondering if her daughter's hospital stay was causing a regression to being more dependent. Other parents may feel that "family music therapy" implies either a problem with the caregivers, or difficulties on the part of the therapist working individually with the child. Two points should be made clear in the introduction. First, that offering supportive therapy does not imply a specific problem in the current family dynamics. The goal is to focus and expand on the family's existing resources and interactions. Second, parents should never feel that they are being enlisted as a form of co-therapist, or that their purpose in the session is to help control the child's behaviors. The therapist may emphasize the idea of "sharing an experience" to indicate the relative equality of the parent's and child's roles in the session.

Parents who have observed a therapy session taking place with their child may have a better idea of what to expect. To parents who are unfamiliar with the process, the

therapist should provide a description of the types of activities to be used. Let the parent know that he or she may be asked to sing or play instruments to familiar songs or in an improvisatory fashion, contribute ideas or song lyrics, and discuss things that come up in the music. This is also a good time to mention that there is no right or wrong musical expression, and that it is a chance for both the parent and the child to explore new ideas.

Describing the difference between musical play and music therapy can be difficult. Family members should not be discouraged from approaching music therapy as a "fun" time. The musical process of a session can be exciting, relaxing, or playful. Yet the therapist's job is not to entertain the patient. Modeling during a session may be the best way to explain this boundary. The therapist will not always jump to the child's or parent's aid at the first sign of frustration. Instead, the goal of the therapist is to provide structure and support through which the patient can come to his own decisions and accomplishments. Most parents will be able to understand this intuitively, as it is also how they treat the child to catalyze his independence. Touching on the idea of both fun and work being part of a session is generally enough to inform the parent.

The other delicate topic in this approach is the change in focus from individual to family sessions. The mother in this situation seemed concerned that by including her in the session, needed attention would be taken away from her daughter. Parents should be aware that in a supportive family music therapy session, there is not one designated patient. This does not mean that taking time away from individual sessions is detrimental to the child's care. Situations where this would be the case are assessed by the therapist. In other families, the child's goals are best accomplished through a combination of individual and family music therapy. As was mentioned in the preceding explanation,

giving support and attention to the parent does not deprive the child. Instead, it highlights the natural resources of the family. Benefits to the child and parents will be discussed below. To assuage the parents' worries, the therapist can point out some of the group oriented experiences and processes that can occur, such as increased communication, the sharing of a normalized environment, and the mutual support offered by family members within the music. It is suggested that parents and children be given the opportunity to ask additional questions after experiencing one or more sessions of therapy.

Child Benefits:

Once a family has agreed to participate in therapy together, the therapist must assess the needs of the participants as individuals and as a functioning whole. The individual should not be sacrificed for the perceived good of the family, yet there is no need to abandon patient-centered goals within the context of the family session. This study will describe some of the benefits children receive from family intervention based on clinical cases. It will then discuss how further participation from family members was elicited to increase the potential benefits for parents. One underlying concept in the conduction of these sessions was reciprocity. The affective contagion of music therapy sessions lent itself to mutual benefits. Accomplishment on the part of the child usually implied a successful experience for the adult, and vice versa.

Seeking parental approval:

One of the most basic benefits to the child is the support and encouragement they can receive from caregivers. Younger children are particularly needy for the approval of their parents as they begin to separate and identify. In one of the examples given above, a

four-year-old boy receiving bone marrow transplant was engaged in improvising a song with the therapist when his mother interrupted. It was obvious to this patient that his mother was not giving her approval for the activity, and she suggested that they try a different song. The boy complied, but seemed hesitant throughout the rest of the session, unsure of how his mother might react to other behaviors. This patient was followed up on two days later, when only his father was present in the room. Before the session, father and son had been acting out adventure stories using the child's action figures. The therapist maintained this engagement by asking the boy to tell her about the characters. They soon began improvising a song about the ongoing adventure.

After observing briefly, the father became involved by asking his son more questions as the therapist sang. Eliciting responses from the boy became a joint effort. The father's genuine interest was like a guiding light for the child. The patient's actions and ideas flowed much more spontaneously than in the previous session. He appeared much more confident about a continuous positive response from the father. In many cases, the therapist fulfills this role of the accepting, freely nurturing parent. While there are still boundaries to maintain in the music therapy session, the therapist can be flexible regarding the expression of fantasy, sadness, anger, joy, or rebellion from the child. This acceptance is helpful in building trust and encouraging the emotional exploration of the child. When a parent is able to take on this role, the child becomes even more confident. After all, mom and dad are the figures on which the child is constantly dependent for his basic needs. The fear of altering the existing relationship by angering or disappointing the parent is reversed. Instead, the child may focus on the joyful experience of pleasing himself and his father simultaneously.

Eliciting the musical response of reflection:

Another way for the caregiver to encourage the child is through musical reflection. This is a technique that is often applied by the therapist in an effort to extend the patient's awareness and promote interaction. Parents seem to pick up on this idea instinctively. The same way an adult may repeat or clarify a child's sentence to help build a verbal vocabulary, repeating or mirroring a musical idea prompts the building of a musical vocabulary. This may consist of a direct repetition of a musical phrase, or it could be following the tempo, dynamics, or rhythmic pattern initiated by the child. One patient who had been participating in music therapy for several weeks seemed to have some difficulty expressing herself spontaneously. She followed the therapist's suggestions well, and was able to engage in playing a variety of instruments and musical styles, but never wanted to initiate musical content. She appeared to become frustrated whenever the therapist loosened the structure by giving her choices in her playing. It was not until the therapist conducted one joint session with the girl's aunt, (her primary caretaker), and led another session while a relative was observing that the girl's spontaneity and joy in the musical experience came to the surface.

The first family session was held shortly before Christmas. The patient's aunt was invited to stay in the room and participate in recreating some of the girl's favorite holiday music. The aunt seemed somewhat nervous about playing the instruments, but she agreed to stay and give the session a try. At first the aunt's level of engagement was close to that of the patient. Each would play their instrument or respond to the therapist's questions, but they seemed to expect that they would be told any minute they were doing something wrong. About halfway through the session, the therapist suggested they create a version

of "The twelve days of Christmas", using as many instruments as they could to create sound effects for each of the twelve gifts. Adding this concrete element seemed to do wonders for the self-confidence of both participants. Here was a straightforward task that they could accomplish with some degree of freedom and spontaneity. The goal was to find a sound or a combination of sounds and motions that represented each gift, but the therapist did not structure the use of the instruments beyond this directive. The aunt caught on quickly, making some suggestions and encouraging whatever sounds the patient chose to use. The family members took turns deciding how to fit in with each verse. By the fourth round, they were exchanging looks and laughing together. It was one of the few times up to this point that the therapist had seen the patient truly enjoy rising to the challenge of the musical task. She seemed to appreciate having another person in the session that was just as unsure of how to approach the instruments! Once her aunt demonstrated a willingness to put her fears aside and throw herself into the experience, the patient quickly followed suit.

In a later session, another of the patient's aunts was sitting in, but did not participate directly in the music. It was obvious from the patient's continual looking in her direction, however, and her laughing and making faces, that she was very aware of the woman's presence. In some situations, this might be more distracting than helpful. In this case, however, having an audience of sorts seemed to take her mind off other concerns. She was much less focused, during this session, on whether or not she was playing the correct notes. After receiving suggestions from the therapist, she experimented with different ways of playing, and asked to repeat one song in order to try some new rhythmic patterns. The patient's aunt smiled, nodded, and gave her

encouragement when she looked up. As was mentioned earlier, the role of the nurturer appears more effective when fulfilled by a family member in addition to the therapist. In an individual session, there is only so much modeling a therapist can do to encourage the child's free use of the instruments. Coming to terms with personal anxieties and expression can be a very gradual process. In this case, the therapist felt that the inclusion of family members created a breakthrough for the patient much sooner than it might have otherwise occurred. The willingness to take a risk and the unconditional support provided by this patient's family helped her to find her own path to personal expression.

Receptive involvement:

In one unusual case, a nine-year-old girl in the PICU was referred for music therapy while she was too weak, (due to heart and kidney problems), to actively participate. The music therapist spoke with the parents, and discussed songs that might be appropriate to play for the patient while she was lying in bed. The parents requested a combination of uplifting religious music, and country-pop songs that their daughter enjoyed. The therapist played several of these songs interspersed with familiar children's music, and softer, relaxing pieces. According to the parents, music therapy seemed to be one of the few times during the day when the patient was not receiving a procedure that she did not sleep. She was helped into a position where she could watch the therapist, and appeared to be struggling to keep her eyes open throughout the sessions. During one particular song, "I hope you dance," the patient would raise her eyebrows in response and almost manage a smile. The therapist encouraged the parents to join in and make use of some of the other instruments. While there was some tentative exploration, they preferred to sit close to their daughter and do what they could to keep her comfortable. Without

their support and suggestions, however, the therapist would have struggled to determine the girl's musical preferences. In this case, receptive listening was a successful approach for the family to share an affective experience.

During the second session with this family, three of the patient's siblings were present in the room. Having gotten hesitant responses from the parents, the therapist encouraged the siblings to use the instruments and join her in playing. After two songs in which they participated in the accompaniment, the therapist suggested an improvisational piece. The children were willing, and asked that it be an upbeat piece, something that might "energize" their sister. They proceeded to engage in a quick-moving, enlivened improvisation, laughing and watching their sister to see if she would react. The patient turned in the direction of the music, and looked back and forth between her mother and the performers. The effect on the patient was not fully visible by her outward body movements. She was aware, however, of what was taking place, and must have experienced some joy at her siblings' efforts. The brothers and sister of the patient appeared very proud of themselves. Aside from the aesthetic experience of creating the music, this may have been the only chance they had to feel they were contributing directly to their sister's care. Sometimes the presence of the parents during such cathartic moments is enough to engender lasting hope.

Parental Benefits:

This study began with the belief that supportive family music therapy sessions could provide unique benefits to the parents of hospitalized children. Several of these potential benefits, (stress reduction, sense of active involvement in the child's care,

rehearsing new roles), were highlighted in the literature review. Additional benefits and outcomes were discovered throughout the course of this study as the therapeutic approach was modified to suit each family. These benefits will be illustrated through their occurrence in the following case study.

Engagement in the musical environment:

M was referred for music therapy shortly after her first admission to the hospital. She had recently been diagnosed with acute myelogenous leukemia, (AML), and would soon be undergoing her first round of chemotherapy. The therapist initially met with M approximately two weeks after her family had learned of the diagnosis. M presented as a tenacious and intelligent eight-year-old with consistently bright affect. During her first session, the patient engaged in improvising with the therapist, as well as singing and playing accompaniment to familiar songs. The therapist inquired about music that she preferred, or that held special meaning for her. M talked about artists such as James Taylor and Jimmy Buffet, music that she and her parents shared together on vacations at the beach. She said that this style of music reminded her of some of her favorite times with her family. The therapist decided to end the session by having the patient use a wooden drum to accompany the song, "I can see clearly now". M's mother, who had gone to run an errand during the session, returned during this song. The memories of which M had spoken, as well as the message of the song, seemed to have a strong impact on Mrs. S. (the mother mentioned earlier in the introductory dialogue). She walked toward the windowed side of the room, facing away from her daughter, and began to cry. M continued to play but noticed her mother's reaction, asking, "What's wrong, mom?" Mrs. S. dried her face quickly and said that everything was ok. The therapist finished the

song and sat with the family in silence for a moment before bringing the session to a close.

The last few minutes of that first session created the beginnings of a three-way alliance between mother, daughter, and therapist. It appeared that both family members were putting in an effort to focus only on positive feelings, at least in that early stage. This seemed to be an ideal situation to work with the patient in both individual and family music therapy sessions. In individual sessions, the patient could be encouraged to express herself freely, knowing that her response would be contained safely in the music. The music offered a non-threatening way to explore her feelings through songwriting and metaphor. In family sessions, which would come later on, the mother's coping skills and positive attitude could be maintained through a supportive therapy approach. The therapist believed that while it was important to give the patient an opportunity to acknowledge all of her feelings, accentuating the positive was a necessary and healthy coping mechanism at this time.

One of the unexpected benefits of this first session was the engagement of the mother in the musical environment. Music therapists often seek to create the musical environment as a first step towards building a therapeutic relationship and assessing the patient's needs. In this session, the primary goal was to engage M in music that would both support her expression and encourage her involvement in a therapeutic alliance. The return of the mother at the end of the session allowed her to participate somewhat vicariously in her daughter's experience. In this case, the familiarity of the song and the presence of clearly associated family memories made a strong impact. It helped the mother to understand not only cognitively the benefits of music therapy for her daughter,

but also to accept the power of the music through her own personal experience. A parent in this situation can appreciate both the aesthetic value of the music, and the underlying connections various aspects of the child's life.

It is suggested by this study that the parent's initial reaction to music therapy be taken into serious consideration when selecting subjects for family music therapy sessions. As was discussed above, a doubtful or disparaging attitude can strongly color the child's therapeutic experience. This case demonstrates the opposite: a strengthening of both appreciation and expectations catalyzed by the reaction of the caregiver. This example also seems to indicate that a parent can benefit from music therapy even if her involvement is not directly tied to the child's participation. While this is not the focus of the current study, the parent's strong personal and emotional connections to the music were taken into account as further rationale for inclusion in therapy.

Sharing the affective experience: (reducing stress)

In the weeks that followed, M explored the instruments and tried various combinations of sounds to create her referential improvisations. She focused on topics and titles that provided an escape for her from the sterility and stress of the hospital environment. The most frequently recurring theme was "The Ocean". Improvisations on this topic, with and without words, seemed to capture her memories of happier times with her family, her struggle with nature's limitations, and her desire to be as free as the waves she created. Mrs. S. would often sit in for part of the session towards the beginning or the end, but also gave her daughter some needed space for herself. When her mother was not present for what she considered a particularly successful improvisation, M would request that a recording be played when her mother returned to the room. Mrs. S routinely

appeared when there were a few minutes left in a session, so that M would not be left alone in her room. On the rare occasion that M's mother was delayed, the therapist would bring the tape to the following session and begin with a playback of the last recorded piece. The therapist gradually compiled a tape of improvisations and songs done with this patient that has accompanied M on each of her subsequent hospital stays.

It was interesting to see during this time how the dynamics of mutual respect played out for this family. Mrs. S. fit into the category of the encouraging parent mentioned above. She would generally be in the room at the beginning of a session, listening, smiling, and sometimes offering questions or words of praise to her daughter. She would then depart on an errand or to get a meal for herself, giving M the space to experiment and interact with the therapist by herself. While she appeared to enjoy the music, she also demonstrated a genuine appreciation for M's independence and therapeutic process. In a similar way, M never seemed upset by her mother's departure. She would concentrate throughout the session, and share some of her more exciting musical adventures upon her mother's return.

At this time, the greatest benefit to M's mother seemed to be the opportunity to share an emotional experience with her daughter. In the hospital environment, the majority of emotional events occurring for a family are focused around sadness, anger, or fear. In total contrast, M's improvisations were joyful, free-spirited, and reminiscent of happier family moments. Being included at her daughter's request in the reliving of these events emphasized for Mrs. S the strength and health that her daughter retained. One of the more immediate effects of music therapy, the reduction of stress and anxiety, was occurring for Mrs. S even in the brief moments she took part in the therapy sessions. The

alleviation of stress seemed to be caused by the positive associations made with these referential improvisations, and the sincerely touching quality of M's music. These momentary respites were a way of normalizing the family's experience, by bringing imagination and beauty into the hospital.

Understanding the child's experience: exploration through metaphor

In the following weeks, M became interested in telling stories, using music both as background support, and for spontaneous sound effects. The therapist began incorporating a time at the end of the sessions where M could share the story recordings with her mother, and all three could discuss the results. Mrs. S. would ask about how particular sounds were created, or what they represented in the story. This encouraged M to explore her own creations more deeply, and to relate her improvisations to experiences that she and her mother had shared. When M's music evoked memories of particular moments in her past, she could describe these in detail to her mother.

In one case, what began as a fairly unstructured improvisation on "the ocean" became focused on a very specific instance. The spontaneous use of M's voice to recreate the sounds of dolphins and seagulls at the shore was later remarked upon by her mother. The image of these creatures was triggered by the sounds. It became apparent that the benefits of family sessions come not only from the creation, but also the memory of shared experiences. As had happened in those few moments in the first session, the music was able to capture the emotional import of a time that mother and daughter had shared. While the therapist was able to discuss these feelings and memories with M during individual sessions, the joy of reliving these moments with her mother was obvious.

As the previous weeks had given Mrs. S the chance to share emotional experiences with her daughter, these sessions helped to give her a better understanding of M's perspective. She was given the opportunity not only to listen, but to act as a form of co-therapist in eliciting verbal interactions and exploration of musical content from her daughter. From her perspective, she was helping to recreate the details of past family togetherness. She could easily engage her daughter in free-flowing conversation relating to the topics of the improvisation, giving them a chance to recapture the give and take of family dynamics outside the hospital environment. From the perspective of the therapist, she was also interjecting herself into the improvisatory experience, and giving her full support to the expression and creativity of the child. Beyond the benefits to the patient, this type of interaction can broaden the parent's horizons so that they are not only aware of, but also an intricate part of their child's health and self-actualization.

The transition period:

It was shortly after this that the therapist began working with M to explore her metaphors more deeply. M's relationship with her mother made it appear that while she depended on her family for love and support, she had also begun to identify with people and ideas outside of her family culture. The therapist used M's stories to help her stimulate this identification process. After telling a story, the therapist would encourage her to describe different characters in detail, and to create improvisations that might represent these characters. It was through this exercise that M seemed to start getting more in touch with some of her feelings of sadness and fear, by projecting these ideas onto her creations. M did not seem to feel the need to share these pieces with her mother,

as she had done earlier. The therapist's belief that mother and daughter were each protecting each other from negative feelings was reinforced.

It was felt that treatment had reached a delicate point of balance. The content of M's personal explorations made her less likely to share these sessions with her mother, but the alliance between the two, as well as with the therapist, had already been established. The therapist believed that it was important for M to be receiving continuous support from her mother at this time, regardless of the referential content of a family session. Giving the mother a sense of continued involvement in her child's care was also an important consideration. Even if M did not choose to explore some of her deeper feelings with her mother present, the awareness and self-esteem of both family members could be promoted through a structured family contact. In this stage of progress, the therapist did not wish to create a split in M's emotional expression, such that only positive feelings would be shared with her mother, while sadness, anger, or fear would be reserved for therapy sessions. The identification process in which M was engaging would be most effective if she could begin integrating her ideas into a single self-concept.

It was at this point that the therapist decided to arrange for a full family session. It seemed that if M was getting more in tune with some of her sadness and uncertainty, she might need a safe environment in which to share these feelings with her mother. Both family members had demonstrated strong coping skills up to this point. The therapist felt that the security of the musical container would support their shared experience. If they were both ready, though hesitant, to explore some of these feelings, the music would act both to elicit emotions and to contain any tension they were willing to face. The therapist mentioned the idea of a family session first to the patient, and then to the mother. The

approach taken was similar to the example given above, although some of the questions had been addressed in previous discussions with the mother.

Communication and Exploration of Boundaries:

When the time of the first family session arrived, M appeared to be in good spirits, and was feeling better physically than she had the previous week. The session began with a non-threatening warm-up: everyone contributed to singing and playing a familiar song. M and her mother each suggested lyrics when the therapist left blanks in the song lines, and both accompanied the melody with rhythm instruments. Mrs. S. kept a steady, lively beat going on a wooden drum, and M shook her whole body along with the maracas in her hands. It was possibly the most physically energetic M had been in any session to date. When the song came to a close, M gave a final rattle of her maracas, and exclaimed, "See mom, I told you music was fun!"

In addition to letting the family members warm-up, (musically as well as cognitively to the idea of this shared session), this first activity also gave the therapist a chance to assess family dynamics that might color the entire session. Several things were noted about the participation of both players. Mrs. S. engaged in the music without hesitation. She seemed to have no inhibitions about her musicality or her multiples roles as mother and musical playmate to her daughter. She also demonstrated a strong focus on her daughter's behavior, without losing the sense of the musical style created by the therapist. She was able to interact freely with both her daughter and the therapist, musically and through facial expressions. The experience of being fully involved in the music as she had never been before helped Mrs. S to communicate more freely with M. It

was as if being happy in this context was fully appropriate, while happiness was generally forced and in conflict with the rest of the hospital environment.

M was as free in her music as usual, if anything displaying additional energy renewed by her mother's presence. She shared the music joyously with her mother, but also exerted subtle controlling behaviors. The way she kept accounts of everyone's lyrical contributions, and made sure she had the final verse, seemed an assertion of her figural role in this music group. The warm-up song allowed M to test the relationship boundaries that had shifted from previous individual sessions. Here, her mother was considered an equal part of the creative process, rather than a casual observer. Both mother and daughter needed to try this relationship out, and decide what changes, if any, would be made to avoid conflict. It seemed that M's immediate decision was to allow her mother free-reign in the music, as long as this did not detract from the attention she desired. The boundary between supportive and figural roles was one that was explored consistently by both participants throughout the session.

Active involvement in the child's care:

The warm-up was followed by a free improvisation with the therapist on guitar, and both M and her mother on the keyboard. The therapist asked that Mrs. S. use the lower half of the keyboard, while M focus on the upper half. M promptly placed a sticker on the center key, so each player would know where the boundary lay. The therapist followed a set chord progression, but otherwise put no restrictions on what could be played. Mrs. S., who had played piano for years, quickly picked up on the chord progression, and was able to use the lower register to provide chordal support, as well as initiate some melodic interaction with her daughter. Neither participant seemed bothered

by having to share the keyboard. The therapist decided to keep Mrs. S. on the keyboard, and switch M to a metalophone for the second improvisation. The keyboard, with which Mrs. S was already familiar from her own lessons, offered the choice of giving harmonic support or relinquishing this responsibility to the therapist in favor of melodic play.

M began experimenting with the metalophone as soon as it was in front of her. She quickly established a repeated four-note motive. She then announced, "This is called Springtime," and the music commenced. Mrs. S. and the therapist joined M at approximately the same time, coming to a quick consensus on a harmonic support for M's melodic exploration. It was interesting to note that despite the title, and the history of maintaining a positive attitude, the piece immediately took on a wistful, reflective air. M did not protest against this seeming disparity, but allowed her playing to remain in the A-minor tonality where it had settled, shifting slowly between the i and iv chords. Towards the end of the piece, all three players seemed to sense a change in the musical mood, and while the therapist's support altered to a more upbeat, supportive harmony in C major, M explored other ranges of the metalophone, and Mrs. S. engaged in a brief melodic interaction with her daughter. The piece took on an ABA form, and returned to the original motive and harmony before concluding with a slow glissando up the metalophone and M's announcement, "I'm done now".

These were the first two music therapy experiences in which Mrs. S was asked to actively participate in her daughter's therapeutic process. While her encouragement and acceptance were beneficial before, she was now providing support directly through the musical content. One of the emphases of the literature review in this study is the parent's desire to be needed by the child. In the hospital environment, caregivers are often

stripped of their accustomed roles by medical staff. In this context, Mrs. S was encouraged to interact with her daughter in a supportive way. Music therapy tasks were designed so that her role was implied in the music, rather than assigned. This gave her the option of harmonic or melodic interplay, and the ability to reflect her daughter's music or pursue her own ideas. Giving choices and control to parents seems as important as offering these things to the child. Parents are likely to feel more successful if the decision to provide support comes from them directly. Rather than placing them in a position of following the therapist's orders, they are restored to a role imbued with authority. The locus of control is shifted so that parents perceive the importance of their contribution to the child's care.

Family cohesion and cooperative work:

M and Mrs. S both expressed enjoyment of their instruments and the interaction they allowed. In order to allow for further experimentation on these instruments, and to support the topic of the previous improvisation, the therapist suggested a song-writing experience on "Spring". M seemed interested in this idea, but hesitant about creating song lyrics. The therapist encouraged Mrs. S to begin brainstorming ideas as a way of modeling and engaging her daughter. This also allowed the mother to take a more figural role in the music. Once Mrs. S began, words and ideas flowed quickly together into a verse and chorus for the song. M listened as her mother spoke, occasionally interjecting a note on the metalophone, which served both to emphasize her mother's words, and keep the attention equally divided between the players. Within the span of a few minutes after the exercise had begun, the lyrical basis for the song had been established. The original verse and chorus were as follows:

The earth is warming,
The trees are budding,
Flowers are blooming,
And birds are singing a happy song.

Spring is here!
Spring is here!
Happy news,
Spring is here!

M began playing around with melodic ideas for the verse, as the therapist set up the harmonic structure. Mrs. S's keyboard style seemed to be freer in this piece, possibly a reflection of her focus on the figural and lyrical content of the song. Rather than concentrating on a specifically grounding pattern, she allowed the therapist to provide the structure, and created an upbeat, contrapuntal accompaniment to her daughter's melody. The therapist initiated the singing of the lyrics, on which M quickly picked up. The song format became flexible as the verse was repeated, allowing M to join in singing. During the chorus, Mrs. S's playing matched the exuberant quality of her daughter's voice, as M cried out joyfully, "Spring is here!" The therapist returned to the verse at this point, leaving space in between the lines to allow for more spontaneous creation. M would fill in these spaces alternately by repeating a line or adding new ideas to the existing format.

M's attention shifted fluidly between vocal interactions with the therapist and melodic interaction with her mother's playing. At one point, this took on an added dimension for M as she had an orienting response to the therapist's guitar. She suddenly appeared to notice the reflection of her words in the sharp change in style of the therapist's playing. This allowed her to increase her range of exploration by interacting directly with the keyboard and guitar through her voice, as well as the metalophone. The music in this improvisation had a bright, spring-like quality that encouraged imagery and

association, resulting in the final version of the song: (additional lyrics in italics were spontaneously provided by M)

The earth is warming
The trees are budding
Flowers are blooming
Babies are sprouting up into the new world, hooray!
And birds are singing a happy song
Open your little eyes and see
Flowers are blooming
Trees are budding
It is springtime can't you see.

The earth is warming
Warmer and warmer
Caterpillars are stretching their bodies
Making cocoons and poof! Butterflies.
Poof! Butterflies.
Butterflies are singing a happy song
Across the big, big, big wide sky.

Spring is here, *hallelujah!*
Spring is here, *hallelujah!*
Happy news,
Spring is here!

The earth is warming,
The trees are budding,
Flowers are blooming,
And birds are singing a very sweet, sweet song.

Spring is here,
Spring is here,
Spread the news across the earth:
Spring is here.

This experience turned out to be a valuable demonstration of what mother and daughter could achieve in working together. While M has shown a consistent interest in story-telling and filling in short blanks in pre-composed songs, making the jump to creating full song lyrics has been difficult for her. Her mother's willingness to try something new and initiate the process had the effect of opening the door to a multitude

of ideas in M's mind. Once the basic song form was constructed, M felt free to alter and expand the existing lyrics. Her spontaneous improvisation showed not only a loosening of inhibitions, but a complete involvement in the here-and-now process.

Because of this interaction, Mrs. S was able to observe directly the result of her contributions on her daughter's well-being. She focused on the affective experience occurring in the moment, rather than the cognitive elements of the exercise. The lyrics she created seemed to match her daughter's enthusiasm, and contained a simple and heartfelt message of joy. Taken separately, the contributions of mother and daughter were creative and appropriate to the topic. The finished product of their combined efforts, however, seemed to encapsulate the overriding family dynamics of loving support and optimism. The therapist believed that continued successful encounters of this nature would help mother and daughter to work together under more stressful circumstances.

Rehearsing new roles:

The closing piece for this session was a song that both M and her mother had mentioned in previous sessions. The therapist played and sang "Carolina in my Mind" while the family improvised and accompanied on their instruments, with Mrs. S also providing vocal harmonies. The song seemed to provide a large container for the emotions and dynamics expressed earlier. It allowed mother and daughter to continue sharing an affective experience, while giving a sense of comfort and security through its familiarity. At times, M would spontaneously join in singing during the chorus, but she appeared more intent on fitting her instrumental playing into the established style. Mrs. S was given the opportunity to take a figural role again, playing along with the melody and growing confident in the use of her voice. By the last verse, her hesitancy had been

overcome by her enjoyment of the song. She sang a strong, high harmonic line over the therapist's melody, and played energetically on the keyboard.

M seemed aware of the change in her mother's musical quality, and temporarily dropped back to a more supportive, open accompaniment. She may have been unused to having her mother receive so much attention, (in the hospital in general, and also in the specific context of the music therapy session), and drew the focus back to herself at the very end of the piece. She played a final, clear ending note, and declared, "I had to put an end on it, or you would go on forever!" She had demonstrated patience and willingness to relinquish the figural role throughout this song. It seemed, however, that with the piece concluded, she had to remind her mother and the therapist that her role was still central to the session. It is also possible that she was reassuring those present that she was the real patient, and that her mother was not truly in need of the therapy being provided.

This family illustrates how involving a parent in therapy sessions can increase the benefits received by each member. Throughout the process of M's treatment, her mother was engaged in a variety of roles in music therapy sessions. Creating a family experience out of M's musical explorations seemed to help mother and daughter develop broader perceptions. M was able to regulate her own anxiety by associating the music with outside experiences, and reminiscing about happier moments spent with her family. Mrs. S. saw how the creative process emphasized M's positive outlook and environmental mastery. Inviting Mrs. S. to become a full participant in music therapy gave the family a chance to share these experiences. Through the family session, mother and daughter became more aware of their adaptive interdependence.

Outcomes:

The information that was gathered and analyzed in this study was used to develop a model of approach and treatment for families in the pediatric hospital setting. The results of the clinical casework as applicable to this model are summarized below.

Assessment:

The first goal of the therapist is to determine which families would benefit most from a music therapy intervention. This decision is based on the needs and capabilities of the family in question. In the literature review, it was pointed out that childhood illness is a chronic stressor for both patient and caregivers. The reaction of the caregiver to these circumstances is the strongest indication of her suitability for family music therapy. While some parents have strong enough internal and social support systems to cope sufficiently with this type of crisis, many mothers and fathers are in need of the additional interventions provided by healthcare staff. Parents that have learned to cope with their own reactions, yet are struggling with their altered roles in relation to their children, are especially suited to a family intervention. These are the caregivers that have the ego strength to use therapy to reduce their own stress, while simultaneously reaching out to engage their child.

The clinical cases reviewed above illustrate parental behaviors that may counter-indicate supportive family music therapy, despite a demonstrated need for additional support. Family dynamics are an important consideration in the reception of benefits from family music therapy. While one of the goals of the supportive family music therapy model is to improve family communication, there is a limit on which types of family interactions can be successfully addressed in the relatively short time of a hospital

stay. The therapist should not be focusing on facilitating major changes in family dynamics. Instead, the goal is to draw out and support the existing strengths of the family that they may learn to accept and cope with the immediate situation. It is suggested by this model that parents with strongly negative or dismissive attitudes towards therapy, parents that demonstrate a need to control their child's behavior, or those with insufficient ego strength to undergo therapy in the presence of their child not be included in supportive family music therapy sessions.

Approach:

Following the decision to include family members in a music therapy session, the therapist should find a time to discuss this idea with the parent(s). Parents should be presented with a brief description of the probable goals and methods of a family music therapy session, and given the opportunity to discuss any questions or decisions with the therapist before the child is informed. Based on previous studies done on family interventions in a medical setting, it is important to note that not all parents will be able or willing to interact with their child at the same level. The therapist can be sensitive to this both during the initial "interview", and throughout any family sessions that are conducted. Parental uncertainty or fear may be manifested in any number of ways, from hesitancy in musical interactions to outright avoidance of a family session. As mentioned earlier, music therapy may be more effective than other interventions in terms of normalizing the hospital environment. Parents and children are given the opportunity to interact in experiences that focus on the health and strength of the family. Providing a parent with all necessary information and then allowing him to make a reasoned decision is the first step towards restoring a balance of control between parent and staff.

Parental concerns voiced during the therapist's introduction should be expected and responded to with clear, honest answers. Convincing a parent to join his child for therapy under false pretenses will eventually be detrimental to all involved parties. It is necessary to address several potentially uncomfortable ideas for the parent, including the role of the parent as a recipient of therapy, the flexible boundaries of the music therapy container, and the therapeutic process that involves a balance of work and fun. The way these concepts are presented to the parents may significantly impact their decision to participate in therapy. The therapist should be prepared to answer questions about these subjects, and to empathize with the parent's concerns for himself and his child. When a parent provides an informed consent to participate in family music therapy, the therapist should then explain to and seek assent from the child. Ultimately, the decision to engage in family music therapy is given to the parent(s) and child involved.

Transitioning:

In the cases described above, family music therapy was an intervention provided in addition to individual music therapy for the child. As was discussed in Lawlor and Mattingly's study of family-centered care approaches, a dichotomy often exists in the healthcare field over the primary focus (child or family) of treatment. Arranging for one weekly session of individual work and one weekly session of family music therapy seemed to balance the needs of these competing interests. In this way, the music therapist's goals for the family, (supporting coping skills, decreasing anxiety, facilitating communication between family members), could be pursued without prematurely ending the child's individual therapeutic process of self-awareness and expression, mastery, and developing problem-solving skills.

It is important that the therapist be clear on the different boundaries and goals of individual and family sessions. While it is likely that there will be some overlap of musical and verbal content from a child's individual sessions, the focus of the family session should be on what is occurring in the moment. Overemphasizing what the child has accomplished individually makes it difficult to engage the parent as an equal member of the therapeutic process. Discussing the content of individual sessions may be seen as a means of keeping the parent informed and active in the child's care. This should be done only when it is relevant to family-centered interactions, and with the child's assent. Forcing a child to address certain issues in the presence of his parents may create a feeling of alienation or even betrayal, as if the therapist cannot be trusted to maintain confidentiality. The therapist must seek her own balance in supporting the child, the parent(s) and the family as a whole.

Restoration of adaptive parental roles:

For the hesitant parent, becoming a peripheral participant may be a necessary first step to full engagement. Some of the examples above illustrate the benefits that can be gained by family members when the parent fills an observing or morally supporting role. Even the relative passivity of the parent as a listener allows her to encourage her child, share in the manifestation of healthy behaviors, and support the child's freedom of expression. The parent is given the opportunity to shift gradually from her "vigilant parent" or witness role, watching from the sidelines as the therapist interacts with her child, to a role in which she is actively engaged in caring for herself and her child.

One of the primary challenges of this method of intervention seems to be creating a new role for the parent in which relaxation and responsibility, ground and figure, and

control and freedom are combined. The goal of the therapist is to facilitate musical experiences that help the parent to feel needed without being burdened by responsibility, to accept the importance of looking after her own emotional health, and to make decisions with clear, observable consequences. This can be accomplished by first engaging the parent in the musical environment, often with the assistance of familiar songs that parent and child have heard or played before. Engagement can be followed with slightly more structured tasks, in which the parent and child alternate between supportive and figural roles. The therapist may assign one family member a grounding rhythmic or chordal accompaniment while allowing the other member to improvise a melody. The roles of the parent and child may be further explored through verbal discussion following a musical piece. Whether acting as background or figure, the parent is given the opportunity to engage actively and share an affective experience with her child.

Through cohesion to closure:

Through the process of role exploration and problem-solving in the musical experience, supportive family music therapy seeks to bring awareness to the parent and child. It is a combined awareness of the self, the other, and the family gestalt in terms of resources, coping skills, communication, and interdependency. In light of this, the process of supportive family music therapy should evolve from an individual to a group focus. It is natural for both parent and child to begin therapy by becoming more in touch with themselves: their thoughts, emotions, needs, and means of musical expression. As this self-understanding progresses, it can be expanded to include the rest of the family, as well as the therapist. Family members are given the opportunity to test boundaries and

roles in the musical context. Consistent support from the therapist and structured experiences promotes further exploration and musical freedom. The pleasure of creativity is enhanced when shared with others. The therapist should, therefore, strive to engage the family members in cooperative efforts, where the contribution of each member can be seen in the completed product. The case study of M and her mother began with a clear focus on the child and her needs. Through discussion, listening, and musical play, Mrs. S eventually became an equal member in the therapeutic alliance. The culmination of this process was the creation of an improvised song in which mother and daughter were each integral parts.

Ideally, the family will share at least one cooperative experience of this nature before the child is discharged from the hospital. The therapist can include these integrative activities into each session, particularly when the family may be leaving the hospital unexpectedly. This type of cohesive experience meets aspects of each of the primary goals in a supportive family music therapy session. Parent and child are engaged in a musical environment and sharing an affective experience, each member has a chance to explore and understand the perspective of the other, communication and testing of boundaries is encouraged, new roles are rehearsed, and both members are actively participating. Beyond the scope of the music therapy session, achieving these goals gives parent and child a more accurate perception of strengths, coping skills, and mutual support. Due to the nature of in-patient treatment, closure of the music therapy process is generally not simultaneous with achievement of all of the family's goals. Instead, the therapist is seeking to support the strengths of the family and provide guidance for further exploration and cooperation outside of the hospital environment.

RESULTS

This study has helped to produce conclusions in two related areas of research: the need for treatment of families in the hospital environment, and the potential for supportive family music therapy to meet this need. The results of these categories are summarized in two tables below. Table 1 addresses problems as identified in the literature review, as well as potential interventions and further applications. Studies are identified by author and year of publication, and can be found under the reference section following the summary. Table 2 looks at these same concerns from the perspective of the music therapist applying a supportive family music therapy model. It is divided according to the sections of the model: assessment, approach, transition, restoration of adaptive parental roles, and through cohesion to closure. Interventions are evaluated in terms of observable results and broader implications.

Table 1: Findings of the Literature Review: Family Needs and Interventions in the Pediatric Hospital

Author, Year	Research Focus	Method	Findings	Implications	See Also
Hamlet, Katz, Pelligrini, 1992.	Impact of childhood illness on family members	Interview	Childhood illness causes stress for all family members. Stress may be affected by type of family interactions.	Facilitating positive interaction between family members may help to reduce anxiety.	Bournes, Mitchell, 2002.
Masters, Cerreto, Mendlowitz, 1983.	Influence of family's pre-morbid state.	Interview, Qualitative Assessment	Status of relationships and psychological wellness in a family prior to diagnosis helps to predict the family's crisis reactions.	Existing family dynamics play a large role in terms of ability to cope and maintain healthy interactions.	
Bradford, John, 1991.	Establishing a family care model	Development and testing of a theoretical model	Involving all members of care (professional and family) in structured meetings helps to alleviate confusion and anxiety.	Parents and professionals both benefit from sharing information. The child's distress may also be lowered through the coping skills of the parent.	
Curley, 1988.	Applying a nursing participation model of care for families.	Application of model and open-ended survey.	Keeping the model flexible to the needs of each family helped to alleviate stress and enhance care-taking roles.	Sharing information with parents and exploring their options as caretakers can be an effective intervention.	
Jay, 1977.	Levels of parental engagement in the hospital environment.	Observation, supportive interventions provided by nursing staff.	Parents are not always comfortable interacting with their child in this environment. Continued relations are necessary, however, to maintain the child's normal growth and development.	Professional intermediaries may be required to facilitate healthy parent-child interactions. Parents should be encouraged but not forced to take on active roles in the care of their child.	McDonnell, 1984.

Lawlor, Mattingly, 1998.	Professional's perspective of family-centered care.	Interview	Medical professionals do not feel adequately trained to address all of the family's needs. They also believe their primary focus should be the patient's health.	Additional staff or training may be necessary to implement family-centered care. Measurable benefits to the child may also need to be demonstrated.	
Carter, 1989.	Assessing hospital stressors.	Quantitative survey administered to parents in PICU.	Parent-child role alteration and uncertainty of how to care for child were rated two of the highest stressors.	Parents seek information from hospital staff as a means of providing better care for their child.	Kasper, Nyamathi, 1988.
Provence, 1990.	Conflicts arising in a family-care environment.	Observational data	A supportive environment helps parents to relax and act with more self-confidence in their care-giving abilities.	Cooperative efforts contribute more effectively to the child's care and a treatment alliance.	Cornish, Kayser, Hansen, 1998.
Snowdon, Gottlieb, 1989.	Roles of mothers in the pediatric hospital setting.	Observation, provision of support from hospital staff.	Mothers tended to take on passive roles in caring for their children. These roles were generally adapted when mothers received support.	Providing support to mothers during hospitalization helps them to take on more active care-giving roles.	
Decuir, 1991.	Normalization of the hospital environment.	Therapy sessions followed by interview.	Musical experiences are associated with life outside of the hospital. These experiences aid families in regaining normal interactions.	Provision of a supportive, non-threatening environment offers families the chance to recognize their own strengths and interdependencies.	Robinson, 1987. Dun, 1995.
Hibben, 1992.	Tension release and emotional discharge.	Music therapy sessions conducted with families with young children.	Parents find they are able to share an affective experience with their child, despite a lack of vocabulary to describe the event.	Typical interactions are re-examined based on family relatedness in the musical context. Parental and child expression is supported and contained.	Harvey, 1990.

Miller, 1994.	Communication and structure in the therapy session.	Analysis of three family therapy models used in music therapy.	Music and the music therapist can relieve tension created by family conflicts. Family members can experience individuality without becoming isolated.	Music therapy offers the potential for communication and shared affective experience at the primary process level.	Robb, 2000.
Feldman, Horn, Ploof, 1995.	Coping strategies as seen by parents and professionals.	Open-ended questionnaire.	Medical staff are uncertain how most families cope with hospital stressors. Parents indicated that normalization of the environment and open dialogue with professionals would be most helpful.	A bridge between parents and hospital staff is needed to facilitate communication and coping. Interventions to normalize the environment could reduce parental and child stress.	Boyer, Barakat, 1996.
Muran, Rosenthal, Winston, 1999.	Use of a supportive psychotherapy model.	Theoretical analysis	Supportive therapy may be used with higher functioning individuals undergoing a crisis situation. Focuses include interpersonal relationships, affect modulation, and frustration tolerance.	Awareness of affect, reduction of anxiety, and strengthening of coping skills are overlapping techniques of supportive and music therapies as applied to this population.	Litecky, 1998.
Jacobowitz, 1992.	Short-term therapy	Clinical casework	Flexibility is necessary so that a therapist's plan can fit the changing needs of the child. Assessment is an ongoing process.	Short-term therapy can be effective, but must take into account certain limitations. Short-term goals should be established first.	
Dewald, 1994.	Supportive therapy goals.	Analysis of techniques.	Supportive therapy uses the existing strengths and skills of a patient to help them address current concerns. Stress reduction is accomplished through a flexible and accepting environment.	Keeping interventions ego-syntonic to the patient's existing character structure allows supportive therapists to accomplish short-term goals. This method is particularly applicable in a crisis situation.	Werman, 1981.

Table 2: Meeting Family Needs Through Supportive Family Music Therapy:

Research Focus	Therapy Goal(s)	Intervention Method	Results	Implications	Section of Model
Impact of childhood illness on family members.	Determining the caregiver's need for family therapy.	Observation of parental behaviors, coping skills, and support resources.	Parents were generally included in therapy sessions when a) the child was 2-5 years of age and demonstrated attachment issues, b) the parent appeared to be having difficulty relating to her child's new needs, or c) the parent showed an interest/ability to support their child's musical behaviors.	Each individual therapist will come to different decisions based on the specific skills they bring to the therapy session. The guidelines provided are based on the clinical experiences and are backed by psychological and developmental theories. Assessment is the first essential tool in conducting effective family interventions.	Assessment
Influence of family's pre-morbid state.	Assessing ego strength and suitability of parents.	Possible exclusion of parents with strong negative attitudes towards therapy, overtly controlling behaviors, or insufficient ego strength.	The therapist modeled the use of flexible boundaries and reflective techniques for difficult parents. In cases where the parents continued to rely on negative or controlling behaviors, the therapist attempted to see the child when the parent was not present.	While there are ways to modify the therapeutic approach so that more parents may be included, (such as involving the parent in limited aspects of a session and making boundaries very clear), the supportive family music therapy model is not ideal in every situation.	Assessment
Establishing a family care model	Introducing family music therapy to the parent(s) and child.	Setting up an initial "interview" with parents to explain the music therapy process and discuss any questions or concerns.	Most parents who fit the assessment criteria responded favorably to the therapist. They seemed to appreciate the opportunity to discuss the care of their child with a healthcare professional.	The therapist is acting here as an advocate for the field. It is a chance both to help the parent understand the child's therapeutic process, and to enlist the parent as a valuable resource.	Approach

Applying a nursing participation model of care for families.	Involving parents in the decision-making process.	Allowing the parent to make an informed choice as to the level of their involvement in therapy.	Discussing parent's options and answering questions honestly was the first step in creating a balanced therapeutic relationship.	Assessment continues in this phase of the model, in terms of convincing a parent to participate despite doubts, or allowing the parent to make the choice not to participate.	Approach
Levels of parental engagement in the hospital environment.	Gaining parent's participation through an observational role.	"Initiating" the parent by having him witness an individual session with his child. The parent is given the opportunity to provide support and encouragement for the child.	Parents with doubts or concerns about the therapeutic process were able to see the benefits afforded the patient. They were also presented with a new perspective on their child by observing him engaged in normal, healthy behaviors.	At this level of engagement, the primary benefits are accrued by the child. He has the chance to create in the presence of a parent, and gain acceptance and approval that are significant particularly for younger children. Parents benefit by witnessing the child's healthy expression.	Transition
Professional's perspective of family-centered care.	Transitioning from individual to family-centered therapy. Maintaining separate boundaries.	Creating a treatment plan that addresses family needs and the continued therapeutic process of individual sessions.	The most successful interventions were those in which the child continued to receive individual therapy, with the parent being included in half of the normal number of sessions. The therapist created separate treatment plans for individual and family sessions, usually avoiding the overlap of content between sessions.	This form of treatment addresses in part the concern of many healthcare professionals that the child should remain the primary focus of all interventions. The patient is not being deprived of the normal therapy sessions. In addition, shared music therapy experiences should benefit the child both directly and indirectly through the reduction of the parent's anxiety.	Transition

Primary hospital stressors.	Involving the parent in active care for the child.	Giving the parent a structured role in the therapy session.	Assigning parents a specific musical part or role assisted in alleviating the stress caused by an unfamiliar medium, while helping the parent realize his direct influence on or contact with the child.	Engagement with the child during the music therapy session may help the parent to adjust to her altered role beyond this context. Creating structure and assisting the child while allowing him to make some personal choices are appropriate behaviors for most situations, including those in the hospital setting.	Restoration of Adaptive Parental Roles
Conflicts arising in a family-care environment.	Balancing therapist and parent power and responsibilities.	Helping the parent to make choices within the musical structure.	Parents may seem surprised at first when asked to work with the therapist in creating a musical task. They respond well, however, to this demonstration of confidence in their abilities, and are usually willing take on an equal share of responsibility for the session.	This builds on the elements of control given to the parent at the introduction to therapy. Here the parents can witness the concrete results of his choices. The therapist also has the opportunity to model choices and behaviors for hesitant or passive caregivers.	Restoration of Adaptive Parental Roles
Roles of mothers in the pediatric hospital setting.	Rehearsing and adapting to new roles.	Switching the parent and child between ground and figural roles in the musical content.	Discomfort with new roles is gradually abated. The child uses the alliance with the therapist to support his caregiver, while the parent is given more freedom in the figural role.	It is hoped that the progress made in adjusting to new roles will continue beyond the scope of the music therapy treatment. Family dynamics are often dramatically altered long after a child is discharged from the hospital.	Restoration of Adaptive Parental Roles

Normalization of the hospital environment.	Engagement in the musical environment.	Warm-ups, use of familiar songs to help reduce anxiety.	Parent and child were able to participate in a variety of ways (singing, playing, moving). The decision-making process was initiated while the therapist was able to assess family interactions.	A musical warm-up is a good way to begin each session. It allows the family to direct their attention to the therapy taking place, and provides an opportunity for assessment. Dramatic physical and emotional changes can take place daily in the hospital environment.	Restoration of Adaptive Parental Roles
Tension release and emotional discharge.	Sharing an affective experience.	Allowing the emotional and thematic content of music and discussions to come from the family's here-and-now experience.	Children especially seemed more likely to respond to a task designed around their input. Expanding on a word or idea presented by the child helps both family members develop more awareness of their associated thoughts and feelings.	The therapist may wish to have a preconceived idea of musical tasks and experiences for the family. These ideas, however, should be flexible to incorporate a variety of spontaneous contributions from both parent and child.	Restoration of Adaptive Parental Roles
Communication and structure in the therapy session.	Facilitating an understanding of the child's emotions and experience.	Using metaphor and referential improvisations to explore the perspectives of parent and child.	Parent and therapist may both be surprised by the associations a child will have with musical content. Verbal discussion to the extent possible is suggested to elicit the child's thoughts and encourage parent-child interactions.	Giving the parent and child an opportunity to talk about the thoughts and feelings they have associated with musical content is helpful to the family and to the therapist. Family members can gain a concrete idea of their differences in perspective.	Restoration of Adaptive Parental Roles

Coping strategies as seen by parents and professionals.	Building problem-solving skills in the musical context.	Creating choices in the musical structure. Helping parent and child to understand the consequences of their choices in a non-threatening context.	Continuous assessment allows the therapist to determine what choices are appropriate to offer each family member. This may range from choosing an instrument to picking a topic for songwriting.	In the context of the music therapy session, decisions can always be changed. Allowing the participants to follow through on choices and decide themselves if their solution was successful is one way of empowering and building self-trust.	Restoration of Adaptive Parental Roles
Use of a supportive psychotherapy model.	Focusing on the here-and-now. Building coping skills to deal with the crisis situation.	Using the therapeutic and musical relationships to experiment, test boundaries, and build frustration tolerance.	Children and parents can both learn to apply the skills they use in creating music to coping with outside stressors. The creative process allows them to work more concretely with tension and release. When a parent sees that her child can tolerate tension in the music, she is more likely to accept the child's strength in other contexts.	Music therapy experiences in a group setting generally allow patients to make the choice between independence or interdependence. The child in particular may surprise himself by being able to resolve conflict in the music. Or, he may become more aware of the presence and support of his parent while making difficult decisions.	Restoration of Adaptive Parental Roles
Short-term therapy	Involvement in a cooperative effort.	Setting up tasks that require the participation of parent and child to achieve successful results.	Awareness is expanded from self to other. Parent and child can see not only the influence they exert on each other, but the possibilities opened by collaborative effort.	Helping the parent and child to recognize their strengths and weaknesses can be invaluable in the hospital environment. Both may come to depend on each other for support throughout the hospital stay and beyond.	Through Cohesion to Closure

Supportive therapy goals.	Emphasizing the existing strengths and coping skills of the family.	Acceptance of the physical, verbal, musical, and emotional offerings of the family. Structuring of the musical tasks so that contributions are seen as a form of mastery over the environment.	Music therapy gives parents and children a chance to positively influence their surroundings. Instead of being acted upon by the environment, they are both placed in positions of relative control. The music acts as a receptive container for everything the family is willing and able to contribute.	Feelings and behaviors that might normally be seen as weaknesses can find potential value in the creative process. Everything from rage to fear to physical pain has its appropriate place in the music. The therapist can encourage expression without pushing the family, through musical modeling.	Through Cohesion to Closure

DISCUSSION

Integration of the Literature and Clinical Work:

The results obtained in this study indicate that supportive family music therapy can be an effective intervention for addressing the parental stressors identified in the literature review. The music therapist was able to facilitate adaptive parent-child interactions by working to normalize the hospital environment. Parents and children used this opportunity to share emotions and experiences in a safe context. The reaction of parents to being involved in the child's therapy reinforces the conclusions of Hamlett et. al's study, (1992). Positive family interactions can be a strong factor in affecting stress associated with the child's illness. The changes observed over the duration of this study may or may not indicate long-term alterations in family dynamics. According to previous studies, maintaining normal family interactions and roles while in the hospital can strongly reduce the stress and conflicts associated with re-assimilating to life outside of the hospital.

Benefits to the parent:

One of the primary gaps in the literature that this study attempted to fill was helping the parent to become more active in the psychosocial care of their child. While researchers have shown that the passivity of parents in the hospital can be a major source of anxiety, the lack of resources and training related to parental needs available to

professionals has left this problem unsolved. In music therapy sessions, parents were active participants in the care of their children. The music therapist provided more structure to parents at first, helping them to become relaxed in the musical environment. Parents were then encouraged through modeling and suggestion to create structure for themselves and their children. Mothers in particular responded well to this method. While most were eager to share these experiences with their child, they looked for guidance from the therapist about how to engage appropriately.

Kasper and Nyamathi, (1988) and Carter, (1989) showed that parental role alterations can be very stressful. While they emphasized the need to address these alterations, Jay, (1977) also cautions healthcare workers about pushing parents too far. Not all caregivers are ready to take on the full responsibility of an ill child. This study demonstrates that a balance can be created between parent and therapist responsibility. Parents took on a variety of roles in music therapy sessions. Those who were hesitant at first to engage observed individual sessions and witnessed the benefits of music therapy to their child. Others required only an "ok" from the therapist to dive in to the therapeutic experience. Increased knowledge and participation in the child's care seemed to lead to a returned perception of internal control for parents. A cooperative alliance was formed between parent and therapist, allowing both parties to benefit and provide better care for the child.

While family-staff relations were not a primary focus of this study, it was inevitable that inclusion of parents would affect their view of the healthcare staff. Many professionals do not have the time required to explain progress or complications to parents in detail. This can generate frustration and an increased sense of lack of control

on the part of the caregiver. Parents that respond to this frustration by becoming demanding are even less likely to receive the information they desire. The role of the music therapist is not to fill in for doctors and nurses when they are unavailable, nor is it to bring family complaints to these staff. The act of spending time with parents, however, and offering patience and support to family needs, seems to go a long way toward creating more trusting and relaxed interactions. Parents that feel their needs are being taken seriously are more accessible to their children, and more likely to bring serious concerns to the staff.

Benefits to the child:

One of the differences between this study and a nursing intervention conducted by Curley, (1988) was the ability to treat parent and child simultaneously. Curley's nursing model worked to address several of the stressors identified in the literature review, such as the parent's lack of information about his child's condition, uncertainty in how to care for the child, and shortage of emotional support. It was clear that the time taken by nurses to share information with parents and discuss their care-taking roles was effective in reducing stress and improving parent-staff relations. This model, however, required that nurses take time away from their normal duties, as they could not attend to the child's needs while working with the parent. Being able to meet the parent's needs without depriving the child of attention or assigning additional responsibilities to existing staff may be a key point in persuading hospitals to implement more family-centered care models. Music therapy is also focused on the relationships created between patients and therapist. Many of the benefits derived from music therapy are based on the trust and working alliance established with the therapist. The families involved in this study did

not appear to suffer any ill effects from joint therapy sessions. Rather, the children seemed more relaxed and spontaneous, allowing them to benefit from therapy to an even greater degree than normal.

Transference and countertransference:

The therapist should be aware of possible subconscious reactions between parent, child, and therapist during family sessions. The first of these is the transference from child to therapist. In an individual session, the patient often experiences the therapist as a parent or other authoritative figure. The therapist may reinforce this perception by fitting into the expected caretaker role, or surprise the patient by altering their expectations. In family session, the role of parent is already being filled. The child may seek out a new role for the therapist: either as the second parent or as a sibling, simultaneously interacting with and competing with the child for the parent's attention and approval. The therapist should be careful to maintain clear boundaries. She should establish herself as a healthcare professional, engaged in facilitating the child's development without usurping the caretaker role.

The second consideration is the parent's transference to the therapist. The parent is likely to be aware of the child's reactions to the therapist, potentially more clearly than the therapist herself. The parent may come to feel that she is in competition with the therapist for her child's attention and approval-seeking behavior. This is another important reason for keeping clear boundaries. The therapist should not be creating additional conflict or stress for the parent. Providing increasing choices and responsibility to the parent is one way to assure her that the music therapist can treat the child without assuming a parental role. The parent may come to view the therapist as an ally in her

child's care. Ideally, the parent will accept the therapist in this role so that the strengths of both adults can be utilized of the well-being of the child.

A third possibility to note is the countertransference of the therapist to the parent. As discussed above, it is sometimes difficult to guide the parent into a position of perceived control and responsibility, when the musical structure and experiences are being facilitated by the therapist. The therapist is viewing the parent as both a resource for the child's well-being, and as a recipient of therapy. This could cause one of two reactions. The first is the desire to become increasingly passive, allowing the parent to take a more active role in the child's care. The second is to attempt to force the parent to relax by creating more structure and controlling the details of the session. It should be noted that the music therapist is able to give more choices and responsibility to the parent without giving up presence and involvement in the musical structure and environment. Awareness of personal reactions to the parent as well as level of involvement can help the therapist to create a balance between active and passive roles.

The occurrences of transference and countertransference also warn about the importance of a music therapist conducting these interventions. Interventions involving recorded music, listening, and relaxation are sometimes provided by nurses and other healthcare staff. While these activities can be beneficial to families, they do not include the social and interactional components of a music therapy session. One of the goals of supportive family music therapy is to facilitate adaptive interactions between family members. This can be partly accomplished through the modeling behavior of the music therapist. While a nursing model such as Curley's is helpful to the parents in a cognitive

sense, the music therapist working with families also addresses the affective and psychosocial needs of each member.

Adaptive family interactions:

Giving the parent an opportunity for emotional discharge seemed to reduce the tension often present between family members. This study supports the belief that when a parent is aware of and attendant to her own needs, she is more likely to be emotionally available when the child needs her. Therapy sessions also allowed parents to witness the healthy behaviors of their children, giving them a more balanced and realistic perspective of the whole child. All family members had the chance to observe each other's strengths and weaknesses in the musical context. Smilkstein's study, (1978) asserts that this awareness of internal and external resources is necessary for healthy family interactions. Parents that can see beyond the child's illness can provide more normalized structure and care after leaving the hospital.

One of the problems of family-centered care addressed by Provence, (1990) in the literature is the tendency of parental anxiety to negatively affect the child. Caregivers that are overtly anxious throughout a session may require individual attention or additional structure in order to continue participation. In this study, the therapist attempted to reduce this side effect by engaging parents immediately in tension-relieving warm-ups. Parents also responded well to seeing their children, (who were more familiar with the therapy), demonstrate relaxed attitudes. The supportive family music therapy approach seemed effective in returning some confidence to parents about their care-giving abilities. This in turn created more balanced relationships between family members.

It is important to realize that while many of the effects of music therapy are based on the therapeutic relationship, the music itself also has the power to create change in family perspectives. One of the aims of supportive therapy is to build the family's coping skills for handling current and future crisis situations. The music serves as a form of self-regulation, a coping skill in itself. Families that have a positive experience writing or recreating a song may find this music to be meaningful on a long-term basis. Many of the patients involved in this study received tapes or lyric sheets of songs they had performed in a session. Others accompanied or sang familiar songs that will now be associated with their time in the hospital. While the therapeutic relationship benefits family members in the here-and-now of the hospital environment, the music acts as a bridge back to life at home. It serves both to normalize the experience of the family in the hospital, and to guide and strengthen the family's resources once the child has been discharged.

Limitations:

Time and family availability were limiting factors in this study. The method of approach was developed through a review of theories presented in the literature and adapted based on clinical experiences and individual family needs. Application of this approach to a larger number of families and measuring the effects using reliable pre and post-tests is necessary to be able to generalize these results. Suitability of families to this model was also discussed. While supportive family music therapy was seen to be effective in treating the families involved in this study, other methods may be required to meet the needs of more resistant parents.

The variety of roles taken on by parents involved in this study indicates that benefits may vary based on level of involvement. A parent that observes a music therapy session conducted with her child will not regain normalized interactions or perception of internal control. This impacts the child's benefits as well, offering less chance for the family members to support one another through the music. The therapist should be aware that many of the benefits to parents and children discussed in this study were achieved only through full engagement of the parent. Involving the parent as an equal participant, however, requires a balancing of power between parent, child, and therapist. Testing out new roles and responsibilities can be challenging for all members in a session. Redistributing power should be gradual, and accomplished by allowing the parent to provide more of the musical structure as therapy progresses.

Role-taking may also be impacted by family cultural differences. Despite the variety of patients seen in this setting, the large majority of caregivers involved in this study were mothers. This was due in part to the visiting schedule of the families, (fathers would often arrive in the evenings when the therapist was not present), but may also indicate cultural values emphasizing the caretaker role of the female. Fathers in some cultural contexts will have to be approached differently, (allowing for more parent-created structure and responsibility), in order to achieve the same results. Other parents may be excluded due to cultural expectations and perception of appropriate roles in the child's care. The therapist should be sensitive to cultural differences when approaching parents for inclusion in family music therapy.

The short-term nature of this intervention did not address the potential re-assessment of family members. Evaluating changes in family interactions and displayed

coping skills could lead to the discontinuation of family music therapy prior to the patient's discharge from the hospital. The family discussed under the "parent benefits" section of the methodology was successfully engaged in adaptive interactions and actualization of coping skills. Having met the primary goals of the supportive family music therapy model, this mother and daughter may have no longer required this treatment. Initiating closure did not become an issue, as the patient was discharged shortly following the final session described. In a situation where the therapist feels that her goals have been met prior to discharge, she may develop guidelines for discontinuing family music therapy. The therapist may re-assess parent and child needs in case of future admissions to the hospital.

The guidelines presented in this paper also leave room for personal interpretation. Each individual therapist is likely to come to her own determination of just what supportive family music therapy and music therapists mean. This approach was designed to be flexible, in order to meet the needs of a variety of families encountered in the hospital setting. The multitude of diagnoses and family dynamic issues that are found in the hospital are unlikely to all respond to a rigid model. The goal of this research was to instead provide a starting point for therapists interested in pursuing family-centered care with a pediatric population. The continued use of family music therapy by a larger number of professionals is necessary to narrow the focus and structure of this method.

Application of the results:

Understanding the application of family music therapy means being able to see the benefits to the parents and children as individuals, the therapist as a part of the

treatment team, and the entire family as a functioning gestalt. Many of the benefits to parents have been discussed above, such as stress reduction, recognition of own needs, emotional release, restored perception of control, and acceptance of situations where control is shared. Additionally, children receive parental support and encouragement, build frustration tolerance, recognize interdependence with the parent, and experience mastery through performance. These are significant even as isolated effects. The overall impact, however, is multiplied by the family's interactions.

When a parent is capable of recognizing her own needs, she is more likely to take time for herself and reduce her anxiety level. This affects the child, because the parent is now able to offer more of herself, physically and emotionally. Stress reduction and emotional release taking place in a therapy session can have similar effects. The return of a parent's perceived internal control can also benefit the child. Parents that feel out of control may try to regain their dominant position by grasping at whatever options are left in the hospital environment. Since there are few choices available already, this leaves even less space for the child to obtain mastery over the environment. Instead of feeling the need to control details and limit the child's experience and expression, the confident parent is able to relax and be flexible to the circumstances. Recognition of the child's health creates mutual benefits. When the child feels that he is seen as strong, healthy, or normal, he is more likely to behave in these ways. His behaviors lead to confirmation of the parent's beliefs, and family life begins to normalize.

As the child receives support and encouragement from his parents, he usually responds by becoming more confident in his expression, and also more willing to seek out the attention of his parents. Parents are thus given the feeling of being needed, an

occurrence commonly lacking in an environment where the child's needs are being met by healthcare professionals. In building frustration tolerance, the child can also prove to his parents that he is not entirely frail or incapable. This is another form of parents witnessing the health of the child as it emerges. The child is entrusted with more of the normal responsibilities encountered with development, and he avoids some of the delays experienced by children who are over-protected out of parental fear. Witnessing a child's dynamics with family members can also help the therapist develop more effective interactions for individual sessions. Perhaps most importantly, the interactions that the therapist facilitates help parent and child to become more aware of their interdependence. While the main goal of supportive therapy is to emphasize a family's strengths, it is natural for strengths and weaknesses to emerge in the course of a therapy session. Family members have the chance to support each other and reaffirm their ability to meet their own needs as a fully functioning unit.

Being aware of how each family member's experience acts as a catalyst to the experiences of others can help the therapist achieve the maximum results in a short-term treatment. As mentioned earlier, the guidelines presented above for a supportive family music therapy model are offered as an aid for therapists looking to initiate family-centered care in the pediatric hospital setting. Each therapist is likely to adapt this method based on specific skills, resources, and circumstances. While the primary interventions used in this study were singing familiar songs, creating referential improvisations, and writing songs, this does not imply that other methods, (such as relaxation and imagery techniques, lyric discussion, or didactic sessions) would not fit within a supportive

therapy approach. Investigating the use of other models and further applications of the approach presented here is discussed below.

Suggestions for Future Research:

One aspect of care that was not addressed in this study was the potential long-term benefits to families. It is uncertain whether the changes that were observed over the course of the clinical work would continue to be effective after patients were discharged. While one of the goals of the study was to provide guidance for families on improving communication, this skill was not followed up on once the family had left the hospital. It is possible that the supportive, here-and-now focus of sessions was only effective in improving relations and reducing stress on a short-term basis. Future studies could include follow-up visits or surveys with families to evaluate lasting effects.

Measuring the effects on parents through tests and interviews is another step to be taken. Pre and post-tests of anxiety levels, perception of internal and external control, environmental stressors, and role in the child's care could be conducted to determine more specific results of the therapy. Multiple measures may be required to obtain an accurate description of the intervention process. It appears that the use of a single measure, such as a locus of control scale, would prevent the researcher from witnessing the full benefits of family music therapy. Open-ended questionnaires could also follow treatment, to see in which areas parents felt family music therapy to be most effective. This data would help to demonstrate where music therapy fits in with the treatment team. Observing the effects of other family interventions such as social work or child life would help each member of the team become more effective in his or her work. Music therapy

is not meant to be an isolated approach. Families will receive the maximum benefits when a variety of interventions are integrated to meet the variety of presented needs.

A secondary objective of this study was to improve the quality of the child's care by improving family dynamics. Distress experienced by the caregiver is conveyed to the child. Reducing anxiety is beneficial not only to the parent, but also to the child that is aware of the decreased environmental tension. Measuring the secondary effects of supportive family music therapy on the child is an important issue to convince healthcare professionals of the need for family-centered care. Since the primary focus of most healthcare settings is the patient, direct benefits to the child are more likely to be of import than benefits to family members. It is suggested that mutuality between child and caregiver be a focus of future studies.

In the effort to meet the needs of the child as well as the parent, this model included guidelines for excluding some caregivers from participation. It was felt that the time-limited nature of the treatment as well as the varying parental roles during sessions was not suitable for all families. Future studies in this area might address other approaches or models of therapy that could better meet the needs of these families. Studies that include all families in treatment without a prior assessment may wish to observe the effects on children in terms of anxiety, level of participation, and general family dynamics. Further research may also be done on the differences between mother and father availability, willingness to participate, and perceived benefits from family music therapy sessions.

A second consideration is the presence of pre-existing problems in the family. While this study focused primarily on "normal" families, healthcare professionals may be

particularly interested in working with families where maladaptive relationships or interactions impact the medical care of the child. One suggestion derived from the work of this study is a family intervention where parents are peripherally involved. This allows for the parents to observe a therapy session with their child, and for the therapist to model more appropriate interactions. Family conflicts may be minimized when the family members are allowed to share an affective space and experience, without the therapist facilitating direct interactions. In situations where dynamic issues remain detrimental to the well-being of parent or child, the music therapist may consider separate sessions with the parent(s) prior to engagement in a family session. It should be noted that this requires additional resources of time on the part of the therapist.

A crisis-level intervention model may also be useful in the hospital setting. While this study concentrated on short-term care, it did not specifically address the needs of families such as those in the emergency room or intensive care unit. One of the observations that becomes more clear in these families is the level of empathy being shared between patient and caretaker. In the literature review, parental distress was identified as a by-product of a child's hospitalization. The severity of this distress may be described as vicarious traumatization, in the sense that family members experience much of the same shock, fear, anger, and pain of the patient himself. Examining the reactions of family members in detail could help the treatment team to provide more effective interventions.

Cost effectiveness is another potentially important aspect of supportive family music therapy. Meeting the needs of parents while the child is in the hospital can be seen as a form of preventative treatment. When family relationships remain relatively stable,

the patient is less likely to experience complications based on role confusion or developmental delays. In addition, reducing the anxiety of parents can improve parent-staff interactions, helping professionals perform their jobs more effectively. The ability of the music therapist to meet the needs of the child and the parent simultaneously is somewhat unique in this setting. Measuring the various secondary effects of family music therapy sessions may demonstrate long-term financial benefits to healthcare systems.

Finally, it is suggested that the use of family music therapy be investigated with other related populations. The goals of this type of intervention are applicable to nearly any family. The need to support existing strengths, develop coping skills, reduce anxiety, and improve communication between family members is not limited to families in a medical setting. Due to the intensity of experience in the hospital environment, the results obtained in this study may have occurred more quickly than with another population. Use of a supportive family music therapy model with parents outside of a crisis situation has the potential to yield entirely different results.

SUMMARY

The purpose of this study was to develop a music therapy approach for use with families in the pediatric hospital setting. Objectives included determining the primary stressors for parents in the hospital setting, addressing these stressors in the creation of a theoretical music therapy model, and evaluating this model through clinical application.

Findings from the literature review indicated that role alterations, lack of perceived control, and inability to provide care for their child caused the most stress to parents. A supportive therapy model was chosen to reduce parental stress and restore a sense of internal control. A variety of music therapy techniques were evaluated in terms of their potential benefits to children, parents, and family relationships. The selected approach combined the use of playing and singing familiar songs, free improvisation, referential improvisation, song writing, and discussion.

Parents with children receiving individual music therapy were engaged in therapy sessions in roles from observer to equal member in the creative process. Parents were first assessed for suitability based on their demonstrated need for additional support, their willingness to participate in therapy, and their level of interaction with the child. Families were then given an introduction to the goals and processes of a supportive music therapy session. Parents were also given the option to observe a session with their child to gain a better understanding of music therapy methods.

Once a parent and child had agreed, the therapist transitioned from treating the child individually to conducting individual and family-oriented sessions. Families with infants were engaged in a slightly different manner than those with school-age or older children. With children of three years of age and under, parents were often asked to provide physical support and assistance for the child. In this way, mothers and fathers still became more active in the care of their children, although their opportunities for musical expression and creativity were limited. When parents were participating with older children, they were encouraged to play a separate instrument, sing, or help in the creation of song lyrics. The primary goals of the therapist in these sessions were to engage the family in a musical environment, to have parent and child switch musical roles, (from supportive to figural), to focus on the coping and problem-solving skills already existent in the family, and to normalize the hospital environment through shared affective experiences.

Clinical work indicated that supportive family music therapy was effective in reducing parental stress and giving parents more active roles in their children's care. Parents who were fully engaged in music therapy seemed to experience a restored sense of internal control. These parents appeared more relaxed and less concerned with controlling the details of their child's expression. The interaction of family members seemed to create a more spontaneous and flowing music therapy session, acting as a synergist to the benefits received by parent and child. These benefits included stress reduction, emotional release, recognition of strengths and weaknesses, mastery over the environment, mutual support, and normalized familial interactions.

While the model presented here seemed effective in meeting the needs of parents in the hospital setting, these results cannot be generalized without further study. It is recommended that future research focus on measuring the effects of family music therapy on the stress and coping skills that were addressed in this study. Additional topics to pursue include the effects of supportive family music therapy on parent-staff interactions, long-term changes in family dynamics, cost-effectiveness of family-centered care, mutuality between child and caregiver, and other models of music therapy as applied to family care.

REFERENCES:

Andolfi, M., Ellenwood, A.E., Wendt, R.N. (1993). The creation of the fourth planet: beginning therapists and supervisors inducing change in families. *The American Journal of Family Therapy, 21*(4), 301-312.

Bailey, L.M. (1984). The use of songs in music therapy with cancer patients and their families. *Music Therapy, 4*(1), 5-17.

Barakat, L.P., Boyer, B.A. (1996). Mothers of children with leukemia: self-reported and observed distress and coping during painful pediatric procedures. *The American Journal of Family Therapy, 24*(3), 227-241.

Barlow, D.H., Brown, T.A., Craske, M.G., Rapee, R.M. (1996). Measurement of perceived control over anxiety-related events. *Behavior Therapy, 27*, 279-293.

Belsky, J., Putnam, S., Crnic, K., (1996). *Understanding how family-level dynamics affect children's development: Studies of two-parent families.* Pennsylvania State University: PA.

Bournes, D.A., Mitchell, G.J. (2002). Waiting: The experience of persons in a critical care waiting room. *Research in Nursing and Health, 25*, 58-67.

Bradford, R., John, A.M. (1991). Integrating family therapy into in-patient paediatric settings: a model. *Journal of Family Therapy, 13*, 207-223.

Brodsky, W. (1989). Music Therapy as an intervention for children with cancer in isolation rooms. *Music Therapy, 8*(1), 17-34.

Campis, L.K., Lyman, R.D., Prentice-Dunn, S. (1986). The parental locus of control scale: development and validation. *Journal of Clinical Child Psychology, 15*(3), 260-267.

Carter, M.C., Miles, M.S. (1989). The parental stressor scale: pediatric intensive care unit. *Maternal-Child Nursing Journal, 18*(3), 187-195.

Carter, M.C., Eberly, T.M., Hennessey, J., Miles, M.S., Riddle, I. (1989). The pediatric intensive care unit environment as a source of stress for parents. *Maternal-Child Nursing Journal, 18*(3), 199-206.

Cornish, P., Hansen, P., Kayser, K. (1998). Family conferences as forums for decision making in hospital settings. *Social Work in Health Care, 27*(3), 57-74.

Curley, M.A.Q. (1988). Effects of the nursing mutual participation model of care on parental stress in the pediatric intensive care unit. *Heart and Lung, 17*(6), 682-688.

Decuir, A. (1991). Trends in music and family therapy. *The Arts in Psychotherapy, 18*, 195-199.

Dewald, P.A. (1994). Principals of supportive psychotherapy. *American Journal of Psychotherapy, 48*, 505-518.

Dun, B. (1995). A different beat: music therapy in children's cardiac care. *Music Therapy Perspectives, 13*, 35-38.

Fagan, T.S. (1982). Music therapy in the treatment of anxiety and fear in terminal pediatric patients. *Music Therapy, 2*, 13-23.

Feldman, H.M., Horn, J. D., Ploof, D. L. (1995). Parent and professional perceptions about stress and coping strategies during a child's lengthy hospitalization. *Social Work in Health Care, 21*(1), 107-127.

Gottlieb, L.N., Snowdon, A.W. (1989). The maternal role in the pediatric intensive care unit and hospital ward. *Maternal-Child Nursing Journal, 18*(2), 97-115.

Haines, C., Perger, C., Nagy, S. (1995). A comparison of the stressors experienced by parents of intubated and non-intubated children. *Journal of Advanced Nursing, 21*, 350-355.

Hamlett, K.W., Katz, K.S., Pellegrini, D.S. (1992). Childhood chronic illness as a family stressor. *Journal of Pediatric Psychology, 17*(1), 33-47.

Hammer, S.E. (1996). The effects of guided imagery through music on state and trait anxiety. *Journal of Music Therapy, 33*(1), 47-70.

Hanser, S.B. (1985). Music therapy and stress reduction research. *Journal of Music Therapy, 22(*4), 193-206.

Harvey, S. (1990). Dynamic play therapy: an integrative expressive arts approach to the family therapy of young children. *The Arts in Psychotherapy, 17*, 139-246.

Hays, C.E., Lovejoy, M.C., Verda, M.R. (1997). Convergent and discriminant validity of measures of parenting efficacy and control. *Journal of Clinical Child Psychology, 26*(4), 366-376.

Heller, T., Roccoforte, J.A., Cook, J.A. (1997). Predictors of support group participation among families of persons with mental illness. *Family Relations, 46*(4), 437-442).

Hibben, J. (1992). Music therapy in the treatment of families with young children. *Music Therapy, 11*(1), 28-44.

Jacobowitz, R.M. (1992). Music therapy in the short-term pediatric setting: practical guidelines for the limited time frame. *Music Therapy, 11*(1), 45-64.

Jay, S. (1977). Pediatric intensive care: involving parents in the care of their child. *Maternal-Child Nursing Journal, 6*(3), 195-204.

Kasper, J.W., Nyamathi, A.M. (1988). Parents of children in the pediatric intensive care unit: what are their needs? *Heart and Lung, 17*(5), 574-581.

Kinsella, G., Ong, B., Murtagh, D., Prior, M., Sawyer, M. (1999). The role of the family for behavioral outcome in children and adolescents following traumatic brain injury. *Journal of Consulting and Clinical Psychology. 67*(1), 116-123.

Lawlor, M.C., Mattingly, C.F. (1998). The complexities embedded in family-centered care. *The American Journal of Occupational Therapy, 52*(4), 259-266.

Leff, P.T., Walizer, E.H. (1992). *Building the healing partnership: parents, professionals, and children with chronic illnesses and disabilities.* Cambridge, MA:Brookline.

Lindahl, K., Malik, N. (1997). *Linking marital conflict to child adjustment: an assessment of dyadic and triadic family processes.* Washington, DC.

Litecky, K. (1998). *A qualitative study of the musical interactions of homeless mothers and their children at a long-term shelter: a multiple case study.* Philadelphia: PA.

Masters, J., Cerreto, M., & Mendlowitz, D.M. (1983). The role of the family in coping with childhood chronic illness. In T. Burish & L. Bradley (Eds.) *Coping with chronic illness: Research and Applications (*pp. 381-407). New York: Academic Press.

McDonnell, L. (1984). Music therapy with trauma patients and their families on a ediatric service. *Music Therapy, 4*(1), 55-63.

McHale, J.P., Cowan, P.A., (1996). *Understanding how family-level dynamics affect children's development: studies of two-parent families.* Rhode Island: Jossey-Bass.

McHale, J., Krasnow, A., Slavick, M. (1997). *Parenting style, marital quality, and family process as predictors of toddlers' personality styles.* Chicago.

Miller, E.B. (1994). Musical intervention in family therapy. *Music Therapy, 12*(2), 39-57.

Molinari, E., Taverna, A., Gasca, G., Constantino, A.L. (1994). Collaborative team approach to asthma: a clinical study. *Family Systems Medicine, 12*(1), 47-59.

Olsson, M. (1997). Social support in bereavement crisis-a study of interaction in crisis situations. *Social Work in Health Care, 25*(1), 117-130.

Pearl, L. (1993). *Family-centered early intervention with infants and toddlers: innovative cross-disciplinary approaches*. 81-101. Baltimore:Brookes.

Provence, S. (1990). Interactional issues: infants, parents, professionals. *Infants and Young Children, 3*(1), 1-7.

Reiss, D. (1981). *The family's construction of reality*. Cambridge, Mass.: Harvard University Press.

Rice, N., Satterwhite, B., Pless, I.B. (1976). Family counselors in a pediatric specialty clinic setting. *Social Work in Health Care, 2*(2), 193-203.

Robb, S.L. (2000). The effect of therapeutic music interventions on the behavior of hospitalized children in isolation: developing a contextual support model of music therapy. *Journal of Music Therapy, 37*(2), 118-146.

Robinson, C.A. (1987). Roadblocks to family-centered care when a chronically ill child is hospitalized. *Maternal-Child Nursing Journal, 16*(3), 181-193.

Smilkstein, G. (1978). The family APGAR: a proposal for a family function test and its use by physicians. *The Journal of Family Practice, 6*(6), 1231-1240.

Stratton, V.N. (1992). Influence of music and socializing on perceived stress while waiting. *Perceptual and Motor Skills, 75*, 334.

Sunde, E. R, Mabe, A. P., Josephson, A. (1993). Difficult parents: from adversaries to partners. *Clinical Pediatrics*, 32(4), 213-219.

Ulman, E., Kramer, E., Kwiatkowska, H.Y., (1978). *Art therapy in the United States. 40.*

Waldon, E.G. (2001). The effects of group music therapy on mood states and cohesiveness in adult oncology patients. *Journal of Music Therapy, 38*(3), 212-238.

Werman, D.S. (1981). Technical aspects of supportive psychotherapy. *Psychiatric Journal f the University of Ottawa, 6(3)*, 153-160.

Winston, A., Rosenthal, R.N., Muran, J.C. (1999). Interpersonal change in supportive psychotherapy. *Journal of Pyschotherapy practice and research, 8*, 55-63.